HOSPITAL ABSTRACTS

A MONTHLY SURVEY OF WORLD LITERATURE

PREPARED BY THE DEPARTMENT OF HEALTH

AND SOCIAL SECURITY

VOLUME 18, NO. 10, ABSTRACTS 1420-1578. OCTOBER 1978

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HOSPITAL ABSTRACTS

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HOSPITALS IN GENERAL

1420. **British hospitals home and overseas.** 14th edition. Maidstone, Whitehall Press, 1978, 52pp. £2.00

This gives details of British achievements in the design, building and equipping of hospital and health facilities, not only in Britain but throughout the world. Topics presented include: University Teaching Hospital, Damascus; Kent Ridge Hospital, Singapore; Sir S. Ramgoolan Hospital, Mauritius; progress in the Grampian and Border areas of Scotland; Royal Masonic Hospital, Hammersmith, London; Hope Hospital, Salford; York District Hospital; Eastbourne District Hospital; Queen's Medical Centre, Nottingham; and Corby Health Centre, Oxford Region.

1421. AUJALEU, E. **Hospital questions: consolidated report.** Strasbourg, Council of Europe, European Public Health Committee, 1977, iv, 51pp.

This report is an updated consolidation of previous reports on hospital organization put out by the European Public Health Committee. It provides a concise survey of the situation in the form of a single document listing the main points. Aspects considered include: hospital units and types of hospital; functions of the hospital; hospital planning and grouping; hospital organization; and the place of the hospital in the health service. Two appendices are included covering the organizational problems connected with practice inside and outside hospitals that could usefully be studied by the European Public Health Committee, and a list of experts who helped to prepare the basic reports.

HOSPITALS IN GREAT BRITAIN

See also Abstract No. 1436

1422. ANDREWS, C. T. **The dark awakening: a history of St. Lawrence's Hospital, Bodmin.** [Bodmin], the Author, 1978, xii, 276pp. £5.50

This book outlines the history of St. Lawrence's Hospital, Bodmin, Cornwall, from 1800 to 1948, when the hospital became the responsibility of the National Health Service. The changes in the conditions of psychiatric care during 150 years are described. The awakening of public interest in St. Lawrence's Hospital has resulted in the hospital no longer being considered as a place of dread. Only a few patients are now compulsorily detained. Strong links have now been created between all branches of medicine and with those who are responsible for the social and mental welfare of the very young and the very old.

1423. ROYAL SOCIETY OF HEALTH. **The N.H.S.: the continuing need for private nursing homes?** London, Royal Society of Health, 1978, 35pp.

These papers were presented at a conference held on 9 February 1978, by the Royal Society of Health, London. Aspects considered by the speakers included: the need for

co-existence and interdependence; the contribution of the nursing home; assessment of need; and the nursing home and the payment of fees.

1424. HOMARD, F., NOTHERS, A. and CLIFF, K. **The use of surgical resources at a GP hospital in an urban area.** *Health and Social Service Journal*, London, 1978, May 26, vol. 88, no. 4593, A25-A28.

An attempt was made to ascertain whether a general practitioner hospital in the Hampshire area could maintain its operating facilities on becoming a community hospital. The following were studied: (i) the use made of these facilities; (ii) the extent to which they could be absorbed into the nearest district general hospital and the local Naval Hospital; and (iii) the Department of Health and Social Security's guidelines on surgical facilities in community hospitals. During the three-month study period in 1976, 280 patients underwent one of four types of surgery: (i) general; (ii) orthopaedic; (iii) ENT; and (iv) gynaecological; representing a normal range of non-urgent cases and helping to reduce waiting lists. The operating theatres were, however, under-used: reasons for which are suggested. Taking a local view, the study suggested that uncomplicated surgery should continue at the general practitioner hospital. However, this conclusion must be tempered by the overall requirements in the health district as a whole and the financial resources available.

1425. BURROUGH, E. J. R. **Unity in diversity: the short life of the United Oxford Hospitals.** [Oxford], the Author, 1978, x, 282pp. £4.95

The 25 years of life of the United Oxford Hospitals from 1948 to 1974, when it lost its identity and unity in the reorganization of the health service, are presented. The people who created the hospitals are described, together with the most important events that took place during that time. A brief history is given of the development of the Hospitals, followed by detailed descriptions of the Chairmen, Board of Governors, administrators, treasury, medical staff, special departments, nursing staff and the changes in the provision of the health service up to 1974.

HOSPITALS IN OTHER COUNTRIES

1426. DEZSY, J. Die Stellung des Krankenhauses im österreichischen Gesundheitswesen. **[The position of the hospital in the Austrian health service.]** *Österreichische Krankenhaus-Zeitung*, Wien, 1978, April, vol. 19, no. 4, pp. 203-204, 206-210, 213-216.

A brief account of the development of public hospital services in Austria and their legislative background is followed by data on Austrian hospitals to-day and some comparisons with earlier years. Of the 285 hospitals, 82 per cent are public and of these 92 per cent are run by local authorities. The following figures are for 1975 (with those for 1970 in parenthesis): beds, 82,936 (79,316); average length of stay, 20.42 days (21.95); patient days, 25.5m (25.8m); bed occupancy, 88.4 per cent (84); admissions, 1,304,221 (1,211,072); beds per 1,000, 10.4. For 1980 12.5 beds per 1,000 are planned (7.5 acute, 5.0 long-stay). Hospitals are financed to the extent of 47 per cent from social insurance funds. An example from one district hospital shows that while costs went up by 51 per cent between 1973 and 1976, the number of patient days by 18 per

cent and admissions by 41 per cent, the cost per patient has gone up only 7.4 per cent. Details are given of an integrated system of social and medical services for a population of 15,000, aimed at ensuring that care and medical treatment were given at the right level and that in-patient treatment was only given when this was medically necessary.

1427. MACHIELSEN, J. A. Enkele hoofdlijnen van de ontwikkeling van het sociaal jaarverslag. **[Some guidelines (for private sector hospitals in the Netherlands) on the production of their social (staffing and administration) annual reports.]** *Ziekenhuis*, Utrecht, 1978, May 10, vol. 8, no. 9, pp. 224-228.

The author sees social management as an independent branch developing alongside economic and medical/nursing management. Its brief history is based on 1950 legislation which for the first time recognizes employees as groups entitled to information. A 1975 investigation into annual reports provided by 64 institutions criticizes these on points of responsibility, direction and presentation. Two separate reports are suggested—one internal for the staff and one external for the public. A 1976 recommendation by the Social Economic Council advises that information should be provided annually by the employer on a variety of topics, such as groups of employees, pension regulations, profit sharing, safety rules, etc. These reports, where directed to the staff, should be written in clear, unambiguous language, critically discuss problems with a view to the future, be reliable, unprejudiced and complete, have a routine layout of subjects and show social management against the background of hospital functions. A model scheme is laid out as follows: (i) financial economic data with a summary of cost accounts, relevant remarks and details of undertakings on behalf of staff, such as pension funds, training facilities, etc.; (ii) number and turnover of staff; (iii) matters of organization, viz. staff management, communications, working conditions, training, organizational development, health care, social work, recreation, etc.; and (iv) structure of organization. The paper includes references.

1428. KONCELIK, J. A. **Designing the open nursing home.** Strousburg, Penn., Dowden, Hutchinson & Ross, 1976, xiii, 175pp.

Designing the modern nursing home can be an extremely complex and time-consuming task involving the expertise of many professional disciplines, as well as the reactions of the community and potential patients. This book considers the background to the situation; the physiological aspects of ageing as design determinants; cultural, social and psychological aspects of nursing home residencies; aspects of planning and building; the design of patient-accessible spaces; recommendations for architectural details and utensils, dinnerware, tools, packaging and consumer products. There are also two papers considering proposals for research and development, and comments from a design advocate.

PLANNING, DESIGN AND CONSTRUCTION

1429. TATTON-BROWN, W. **Wrong diagnosis for hospitals.** *Building*, London, 1978, May 5, vol. 234, no. 7035, pp. 47-49.

The author was Chief Architect for the Ministry of Health from 1959, at the start of the National Health Service building programme, to 1971. In this paper he discusses

the basis on which the hospital design programme was developed. Shortly after retiring he spent a period in hospital as a patient in a 30-bed public ward of the old Nightingale pattern. This led him to reconsider and question some of the premises on which hospitals were being designed, particularly the condemnation of large open wards. He suggests that better results might be achieved by allowing greater freedom to individuals working in closer collaboration with local users. The question is how local initiative can be reconciled with centralized finance and where the line should be drawn.

1430. Krankenhausplanung: zentralisieren oder dezentralisieren. **[Hospital planning—centralization or decentralization.]** *Öffentliche Gesundheitswesen*, Stuttgart, 1978, April, vol. 40, no. 4, pp. 214-221.

The West German Hospital Finance Act, 1962, requires each *Land* to draw up a hospital plan to provide an integrated, graded system of hospitals and hospital services. This should aim at providing an efficient service on an economic basis. This paper discusses how this can best be achieved with particular reference to the Schleswig-Holstein plan. The correct balance has to be struck between a too-centralized system, with huge hospitals giving a remote, impersonal hospital service and a too-decentralized system with very small local hospitals and inadequate equipment and care. The view of Schleswig-Holstein is that no hospital should have less than 300 beds: such a hospital should have departments for (at least) surgery, medicine, gynaecology and obstetrics, X-rays, and anaesthesia. Hospitals of the district type (with up to 600 beds) should have an additional department for paediatrics. The larger university hospitals should be divided into autonomous units to provide the necessary degree of decentralization. While basic planning is to be centralized the actual provision of hospital services should be as decentralized as is consistent with an efficient patient-oriented service.

CONSTRUCTION METHODS AND BUILDING MATERIALS

See Abstract Nos. 1433, 1437

HOSPITAL DESIGN

See also Abstract Nos. 1428, 1466

1431. Moss, R. **Hospital design and the National Health Service: an assessment of the main methods used to give guidance on planning and design and the procedures to be followed. Part 3. Discussion and conclusions.** (M.A.R.U. 1/77) Medical Architecture Research Unit, Polytechnic of North London, 1977, ii, 69pp. £2.00

This study covers the subject of hospital planning from the inception of the National Health Service to the introduction of the 'Systems and Standards' approach to design within the Department of Health and Social Security. The study presents a discussion of two areas in a hospital—the out-patient department, and the accident and emergency department. The conclusion is drawn that DHSS design and planning guidance cannot continue to be effective with the changes that are taking place in the health service and the economic climate in which it functions. It is suggested that future planning guidance

should not be merely activity based but be concerned with a clearer understanding of medical organizations. Two appendices are included, presenting lists of projects studied and lists of completed and current projects.

1432. DOUGLASS, R. **Forward-looking architecture: flexibility with change in mind.** *Hospitals*, Chicago, 1978, Feb. 16, vol. 52, no. 4, pp. 113-114, 116, 118.

Hospitals are influenced by a wide variety of complex and shifting outside forces. In responding to these influences they have many architectural options. Whether meeting current changes or planning for future ones, hospitals would do well to incorporate the following features: structural support that allows for vertical expansion; square, rectilinear or triangular configurations which are easier to expand than circular, elliptical or long and narrow shapes; a corridor and stair circulation system that anticipates future horizontal expansion; easily adaptable building materials; movable partitions and free-standing, movable rather than built-in shelves and cabinets; plumbing conduits on outside walls or in stairwells; easily accessible electrical wiring; and ample floor-to-floor heights to accommodate services.

1433. GOODWIN, P. **Fast track and flexible design cut costs.** *Hospitals*, Chicago, 1978, Feb. 16, vol. 52, no. 4, pp. 139-140, 142.

The construction of an additional 10-storey tower at Hillcrest Medical Centre, Tulsa, Okla., and its connection to the main power plant and expansion of the power plant involved several unique features: (i) the 'fast track' method of construction was used; (ii) the hospital, rather than an outside firm, provided construction management for the project; (iii) a guaranteed maximum price contract was obtained in an inflationary economy, prior to completion of the working drawing documents; and (iv) all savings on the construction project were returned to the hospital. The method of construction required a major commitment of time, talent and attention on the part of the hospital, but it resulted in savings on construction and on the long-term operation and use of the facility.

1434. REES, F. W. and BURCH, E. **Barrier-free design reflects spirit of the law.** *Hospitals*, Chicago, 1978, Feb. 16, vol. 52, no. 4, pp. 121-122, 124, 126.

Section 504 of the United States Rehabilitation Act of 1973 requires that all institutions receiving federal funds ensure that handicapped persons have access to all of their programmes, services and employment opportunities. Hospitals may choose to comply with the American National Standards Institute's requirements which are minimal or adopt the barrier-free or 'civil' approach which is more in keeping with the spirit of the law. This paper discusses the consequences of adopting the barrier-free solution, with particular reference to three adjacent facilities of the Oklahoma Health Center, Oklahoma City. Generally, meeting the requirements of the Act will result in the allocation of more square footage per person in public areas as well as in public rest rooms and parking facilities. The additional space does not significantly increase the cost of standard construction techniques.

1435. THWEATT, A. A. **Regulations challenge hospitals to find better design solutions.** *Hospitals*, Chicago, 1978, Feb. 16, vol. 52, no. 4, pp. 129-130, 132, 134, 136.

The complex functions of a hospital and various constraints, particularly regulatory constraints, reduce the number of possible solutions to design problems. Dealing with

regulatory codes can be quite perplexing, but when they are approached in the proper sequence with other design elements, successful design solutions can be achieved. This paper describes how hospitals can comply with regulations and, in the process, design better facilities through careful planning with the architect, the project team and the code officials. Examples are given from three actual projects.

DESIGN OF INDIVIDUAL GENERAL HOSPITALS

1436. WILLIAMS, A. and others. **Duchess of Kent's Military Hospital.** *Building*, London, 1978, May 12, vol. 234, no. 7036, pp. 83-90.

This new military hospital at Catterick Camp, North Yorkshire, was built on an area of waste ground bounded by a railway embankment to the north and the Burrel Beck, a small stream, to the south. The aim was to design a convenient, compactly planned hospital preferably with horizontal communications. The hospital follows race track plan principles which facilitate communications between the wards. The building is divided into compartments to facilitate movement of patients in case of fire. The deep plan building has internal courtyards to provide adequate light and natural ventilation. The Oxford method was used in the construction of the building. Plans, photographs and a cost analysis are included.

1437. VANDEGRIFT, R. A. **Construction manager helps steer project through constraints.** *Hospitals*, Chicago, 1978, Feb. 16, vol. 52, no. 4, pp. 145-146, 148.

This paper describes the use by Lawrence (Kans.) Memorial Hospital of the construction management approach in the building of a 156-bed addition. The construction management firm was appointed prior to the schematic design stage. At the first meeting of the administrator, hospital consultant, architect and construction manager, the total project budget was reviewed and a schedule for each design phase and for construction established. The estimate presented at the end of the schematic design stage was $600,000 over budget; as a result items that could possibly be eliminated were identified. During the design development phase, the planning team met regularly to discuss many alternative systems and designs. At the end of this phase, another estimate was provided—$65,000 below budget. During the working drawing or contract phase, financing was settled and tendering carried out. During the construction period, the construction manager provided a project manager and field engineer on site. Use of the construction management approach enabled the project to be completed on schedule and within the budgeted price.

DESIGN OF SPECIAL HOSPITALS OR UNITS

See Abstract Nos. 1429, 1526, 1575

ENGINEERING SERVICES

TRANSPORT IN GENERAL

See Abstract No. 1544

MAINTENANCE OF BUILDINGS AND EQUIPMENT

1438. HIERGEIST, A. Aufgaben und Probleme der Wartung, Instandhaltung und Instandsetzung haustechnischer Anlagen in Allgemeinkrankenhäusern. **[Tasks and problems of servicing, maintenance and repair of domestic engineering equipment in general hospitals.]** *Österreichische Krankenhaus-Zeitung*, Wien, 1978, Jan., vol. 19, no. 1, pp. 37-62.

This is a detailed account, with a survey of the relevant literature based on 108 references, of the servicing, maintenance and repair of the technical installations in hospitals. It includes among other things: definitions of servicing and maintenance; planned maintenance; useful life of equipment; reliability; causes of failure; organization of maintenance; staffing; costs and minor repair work.

VENTILATION AND AIR-CONDITIONING

See also Abstract Nos. 1466, 1502

1439. MORGAN, W. R., MANEVICH, M. B. and HEISS, L. W. **Planning team programs energy-conserving systems for satellite unit.** *Hospitals*, Chicago, 1978, Feb. 16, vol. 52, no. 4, pp. 157-158, 162-163.

The Atlantic City Medical Centre/Mainland Division, Pomona, N.J., is a 110-bed satellite facility with ancillary services and an emergency/ambulatory care centre. It consists of: a Y-shaped patient building; an adjacent ancillary services building; and an energy-producing facility 120 feet north-west of the main buildings. The energy-producing facility contains oil-fired boilers, emergency generators, the electrical distribution system, water supply and treatment systems, pumping system, a cooling tower, and electric chillers. Advantages of the separate facility are as follows: space in the hospital is no longer occupied by pipes and flues; there is no cooling tower on top of the hospital and no discharge close to it; improved safety; expansion horizontally or vertically is easier; and consolidation allows better supervision. The plant serves the facility through a four-pipe fan coil system with the supply and return pipes underground. Plans and photographs are included.

EQUIPMENT, FITTINGS, FURNITURE

BEDS, COTS, ETC.

1440. BLISS, M. R. **The use of Ripple beds in hospitals.** *Hospital and Health Services Review*, London, 1978, June, vol. 74, no. 6, pp. 190-193.

In an attempt to discover the cause of the apparent failure of alternating pressure mattresses in preventing bed sores, a survey was carried out of all the mattresses in a geriatric unit of 119 beds. Fifty-one patients had large-celled 'Ripple' beds; more than half were incorrectly set up and at least 30 had mechanical faults. Experience in other hospitals seemed to be similar. This situation had occurred because: (i) no provision had been made for servicing the motors and mattresses; and (ii) most of the mattresses

supplied were not very robust. Re-organization should begin by: (i) reducing the number of 'Ripple' beds in each hospital; (ii) training a technician to deal with them; and (iii) providing a room suitably equipped for laying out mattresses for testing and cleaning, testing bed motors, and storing replacement parts.

EQUIPMENT GENERALLY

See Abstract Nos. 1438, 1504

MEDICAL EQUIPMENT

1441. TROTMAN, R. E. **Services to bioengineering in the United Kingdom.** *Journal of Medical Engineering and Technology*, London, 1978, May, vol. 2, no. 3, pp. 115-124.

This paper presents information about organizations at least part of whose function is to provide a service (in its broadest sense) to bioengineers (and other scientists and technologists) working in hospitals, universities, research institutes and industry. The organizations include: the Department of Health and Social Security; regional health authorities; the Medical Research Council and its research establishments, units and groups; grant-making trusts; government research laboratories; UK Atomic Energy Authority research establishments; the Association of Consulting Scientists; the Fulmer Research Institute; the Scientific Instrumentation Research Association; university industrial liaison units; 'Interlab' co-operation scheme; the National Research Development Corporation; the Bath Institute of Medical Engineering; the Design Council; trade associations; learned societies; King Edward's Hospital Fund for London; the Institute for Operational Research; the Nuffield Centre for Health Services Studies; the Hospital Engineering Centre; and the Society for the Advancement of Medical Engineering.

ELECTRONIC EQUIPMENT

See Abstract Nos. 1504, 1560

STAFF GENERALLY

See Abstract No. 1427

STAFF COMPLEMENTS

See Abstract No. 1468

RECRUITMENT AND MANPOWER

See Abstract No. 1576

STAFF MANAGEMENT

See also Abstract No. 1448

1442. PIHL, K. M. Noen betraktninger rundt styre- og rådstrukturen i sykehussektoren. **[Some views on management and consultation in the hospital sector.]** *Norsk Sykehustidende*, Oslo, 1978, April, vol. 51, no. 4, pp. 77-81.

Norwegian law contains an Act (*Stortingsmeldingen* 28 (1976-77)) ensuring the right of public employees to be consulted regarding the management of their place of employment. The Administrative Councils represent a formalization of a system already operating in most hospitals. Government does not consider the Departmental Councils proposed in the Holler Report necessary; their work can easily be done by the departmental administration, particularly if it is open to representation from the various professional groups employed. Ward Conferences are a necessity, and already operate in some hospitals today, where they constitute a valuable internal communication facility. General Meetings would be used to test opinion on matters of general staff interest (payment by cash or cheque; car parking facilities), but it is doubtful if their conclusions could be considered binding on the hospital management. Under the Working Environment Act (*Arbejdsmiljøloven*), a co-operative council must be kept informed of all intended changes in internal organization, plans, staff policies, environmental factors and equipment (except major capital purchases and buildings). The departmental administration, under the chairmanship of the consultant, is responsible for the policies and running of the department, real responsibility being delegated downwards to staff from management by law. Areas for which the departmental administration is responsible are: (i) financial and administrative questions; (ii) staffing; and (iii) professional medical problems. The system should contribute to a more meaningful employment situation for the staff and better hospital care for patients. The article is illustrated with a diagram illustrating the new administrative structure.

STAFF RELATIONS

See Abstract Nos. 1442, 1463

STAFF TRAINING

See Abstract Nos. 1449-1451, 1456, 1458, 1459, 1481, 1505, 1521, 1552

STAFF WELFARE

See Abstract No. 1520

SPECIAL CLASSES OF STAFF

MEDICAL STAFF

See Abstract Nos. 1505, 1514

NURSING STAFF

See also Abstract Nos. 1557, 1571

1443. KOHNKE, M. F. **The case for consultation in nursing: designs for professional practice.** New York & Chichester, Wiley, 1978, xv, 185pp. £9.25

The present practice of the professional nurse and the clinical specialist in the United States is discussed. The definition of these practices through the literature is compared with the factors which in current institutional policies, structures or in the thinking of the nursing profession prevent nurses from realizing their full potential. Aspects discussed include: professionalism in nursing; the development of the clinical nurse specialist; professional nursing and education for practice; the role of the clinical nurse consultant; designs for professional nursing practice; problems for professional practice in the hospitals; curriculum design for the Masters' candidate in nursing; and perspectives for the future. An appendix summarizes statements in the literature about the knowledge base, responsibility, and role of the professional nurse and the nursing technician from the late 1940's to 1971. A bibliography of 70 items and an index are included.

1444. SHEAHAN, J. **Ward sister—manager, nurse, or teacher?** *Nursing Mirror*, Sutton, 1978, May 18, vol. 146, no. 20, pp. 18-21.

A ward sister must be a good manager able to: (i) communicate with nurses, patients and other staff; (ii) control the evaluation of performance; and (iii) co-ordinate ward activities. In the practice of nursing, the ward sister must show skill in human relations and manual dexterity. In the nursing process, she must be able to make assessments quickly and establish priorities. These points are demonstrated by reference to a series of possible events in a ward. In her role as a teacher, the ward sister, by virtue of her status, can stimulate learners to attend and to make observations and she will inevitably play a part in helping the student nurse to become part of the hospital environment. Teaching patients forms another important part of her work. The demands made upon the ward sister are diverse, but the three areas with which she is involved, management, nursing and teaching, all share the same concept of fulfilling objectives.

1445. MAGGS, C. J. **Towards a social history of nursing. 2.** *Nursing Times*, London, 1978, May 25, vol. 74, no. 21, occasional paper pp. 57-58.

State registration in nursing for women marked an important step in the status of this type of woman worker who was usually from a lower middle class background. Nursing now forms a part of the social history of women's work and social roles. Viewed in this way, questions of sexuality, sexual divisions of labour and class and family relationships arise. A record of oral evidence from nurses long retired, together with histories of individual hospitals and institutions, would provide material for both historical research and future analysis.

1446. **Development of the nursing services in Scotland.** *Nursing Mirror*, Sutton, 1978, May 4, vol. 146, no. 18, supplement pp. i-xvi.

Following an introduction, this feature includes short papers on: planning structure and system; nurse manpower planning; the organization of midwifery services;

planning play for children in hospital; long-term health care; the mentally ill and handicapped; the elderly; recent developments in nursing education; and a modular comprehensive educational programme for all nurse students and pupils.

1447. IVESON-IVESON, J. **Nursing—the Danish way (2).** *Nursing Mirror*, Sutton, 1978, May 18, vol. 146, no. 20, pp. 8-10.

The State University Hospital (Rigshospitalet) in Copenhagen has one of the 34 nursing schools in Denmark. Prospective nurses must be 18 years or over and after a six-month preliminary course they work for three years within the hospital, with one study day a week, and are paid £360 a month. Examinations are a continuous process, the marks being cumulative, and the final failure rate is very low. Danish nursing has found a compromise between trade unionism and care for the patient and is coping well with the problems of inflation and unemployment currently facing the Danish health service.

1448. EUSANIO, P. L. **Effective scheduling—the foundation for quality care.** *Journal of Nursing Administration*, Wakefield, MA, 1978, Jan., vol. 8, no. 1, pp. 12-17.

To stress the importance of staffing as a management function, this paper focuses on one element, scheduling, and offers cyclical scheduling as a method which can remedy many common problems. Cyclical scheduling is a technique for assigning work days and time off in a pattern that repeats itself whilst still paying heed to the need for proper numbers and mixes of staff, continuity of patient care and work groups. Its advantages are outlined and the importance is stressed of the premises and policies on which it is based. Clerical staff can be involved in the scheduling function if their responsibilities are defined and well understood and if proper training is provided. Three examples of cyclical schedules are presented.

1449. ALTSCHUL, A. **Education and the role of nurses.** *Nursing Times*, London, 1978, May 25, vol. 74, no. 21, pp. 885-887.

The author suggests that the role of the nurse depends upon the patient's view of his needs. She discusses in general how much the qualified nurse should be concerned with administration, leaving much of the care of the patient to auxiliaries and students. The dichotomies involved in the nurse's role makes it hard to decide who are the most suitable candidates and what type of education they should receive. Teachers need to be persuaded that nursing has a great deal to offer to bright pupils. The modular system would allow all students to come into the profession at their own level. We need some nurses to carry out research in universities, but to train all nurses in educational institutions, as in the United States and Canada, would be very expensive. The system of patient care in which not everyone who nurses is a nurse is worthy of further study.

1450. GIROUARD, S. **The role of the clinical specialist as change agent: an experiment in pre-operative teaching.** *International Journal of Nursing Studies*, Oxford, 1978, vol. 15, no. 2, pp. 57-65.

In this study, 36 nurses and 80 patients in two units of a general hospital were used to test the importance of pre-operative patient teaching. One unit was experimental

unit and the other control. Items on a questionnaire for the nurses covered: (i) the importance of patient teaching; and (ii) items related to teaching activities. Results showed that nurses were uncertain of their role as patient teachers and that very little pre-operative teaching was given. A four-week course given by a clinical specialist did not make opinions about pre-operative teaching more positive, but increased performance significantly.

1451. NUMEROF, R. E. **Assertiveness training for nurses in a general hospital.** *Health and Social Work*, New York, 1978, Feb., vol. 3, no. 1, pp. 79-102.

This paper describes the first stage of an assertiveness training programme for staff and managerial nurses in a general hospital. The programme was conducted for a group of 25 female nurses by a clinical social worker. Special problems were raised in the group and their origins discussed. The group focused on the role of the professional nurse and the relationships between doctors, nurses and patients.

1452. CUNNINGHAM, R. **Participant observation: a research technique in public health nursing.** *Canadian Journal of Public Health*, Ottawa, 1978, March/April, vol. 69, no. 2, pp. 101-106.

The article discusses the problems and advantages of using participant observation as a method of data collection in public health nursing research. Examples of applications of the technique are drawn from three public health nursing visits and are used to suggest ways of overcoming the problems involved. The author selected the nurses to be observed, with their consent, and patients and families were selected according to certain criteria. Observation of nurse and patient meetings were carried out with varying degrees of participation; full, partial, or minimal, the author preferring the last of the three. For each of the studies completed by the author, three data sheets were designed: (i) observed visit data sheet; (ii) review of record data sheet; and (iii) interview schedule. The following procedures produced reliable data collection: (i) precise definition of research questions; (ii) specification of relevant behaviours; and (iii) definition of qualifications and responsibilities of the participants. Both nurses and patients reacted favourably to the system.

1453. TAYLOR, S., SENN, S. and POTTON, R. **Patient-nurse dependency.** *Nursing Times*, London, 1978, May 4, vol. 74, no. 18, pp. 755-758.

A study at Leybourne Grange Hospital for the mentally handicapped attempted to measure the nursing requirements of different types of patients. Only direct nurse-patient contact was observed and the following care groups were applied: (i) patients requiring no help with dressing; (ii) patients requiring complete help with dressing; and (iii) all other patients. Nursing availability was also taken into account when calculating how much attention a patient received. The amount of attention each patient should expect to receive was estimated by use of a weighting system and a ward workload index was calculated. Nurses usually spent less than 25 per cent of their time in direct patient contact, and as little as 15.4 per cent on low dependency wards. Allocation of staff on the basis of workload, which would help high dependency wards, is recommended.

1454. DAVIDSON, S. Van Sell, and others. **Nursing care evaluation: concurrent and retrospective review criteria.** St. Louis, C. V. Mosby, 1977, xiii, 420pp. £11.20

With the enactment of Public Law 92-603 in 1972 the Professional Standards Review Organization (PSRO) was established in the United States. However, there has been considerable concern about nursing quality assurance schemes throughout the country because of a lack of understanding about PSRO regulations and the Joint Committee on the Accreditation of Hospitals audit requirements, a lack of uniformity in approach and the absence of norms, standards and criteria guides. The introductory section to this book discusses the implications of PSROs in the health care setting and the role of the nurse. Model nursing criteria sets for over 250 major diseases and medical conditions are arranged in alphabetical order for quick reference and amplify and expand doctor's criteria by providing for psychosocial needs; patient education; discharge planning; adaptation to health status; retrospective criteria; and critical nursing management for complications. Three appendices are included in the form of: a bibliography (pp. 401-405); the performance evaluation procedure (PEP) forms developed by the Joint Commission on Accreditation of Hospitals; and a glossary of terms.

1455. STRUMWASSER, I., CHERNISS, C. and EGNATIOS, E. S. **The plight of the nurse in community mental health centres.** *International Journal of Nursing Studies*, Oxford, 1978, vol. 15, no. 2, pp. 67-73.

The extensive use of paraprofessionals in United States community mental health centres has drawn attention to the lack of in-service training for both untrained and nursing staff. Of 94 full-time mental health centre staff studied, 46 were paraprofessionals, eight were nurses, and 40 trained non-nursing mental health staff. Results showed that nurses rated their previous supervised experience as inadequate for their present work. They reported less self-confidence in all but one of the areas of community health studied than did the non-nursing professionals, although the nurses actually spent more time in contact with patients. These results suggest that: (i) training schemes for mental health nursing need to include more preparation for psychotherapeutic roles; and (ii) community mental health centres need to provide more in-service training and supervision.

1456. BARRE, K. De faste aftensygeplejerskers behov for undervisning på en åben psykiatrisk afdeling: aften- og nattevagten støttes ved møde med dagens behandlerteam. **[The training of the regular open psychiatric unit evening nurse in Denmark. Evening and night duty nurses would be helped by having meetings with the day care teams.]** *Sygeplejerskens*, København, 1978, May 10, no. 18, pp. 26-30.

The nurse on late duty is alone with the ward's patients, a situation which has the advantage of giving her plenty of time, but can lead to feelings of uncertainty and isolation from other staff. The nurse's reaction to her feelings of anxiety reflect her personality and training: she may feel aggressive, and write long, time-consuming reports to the day staff, or become aggressive and authoritarian towards the patients; she may feel aloof and apart from her patients; or she may feel the effort is hopeless, and give up or isolate herself. The reason for the problem is lack of adequate training, but a temporary solution, which could be applied at once, is the introduction of an hour's paid conference for all staff once a week, to discuss attitudes to patients

and to each other. The aim is to produce continuity in the overall treatment programme throughout the 24 hours, discussions being based on the individual (problem) patient. In a unit where these meetings are practised, an evaluation meeting is held once every six weeks. The experiment is considered a success and recommended to other hospitals. There are 23 references (all Danish).

1457. HARDIE, M. and HOCKEY, L. **Nursing auxiliaries in health care.** London, Croom Helm, 1978, 217pp. £7.95

This book is composed of a series of papers presented over four working days at a workshop held at Edinburgh University, organized by the University Nursing Research Unit and the International Hospital Federation. Four topics relating to auxiliary employment were discussed: training, team integration; supervision; and organizational models for the future. The book is in four sections: the role of the nursing auxiliary; the international background; case papers; and discussion summaries. There are also lists of contributors and participants, a comparative international table indicating length of training, a summary of the workshop and an index.

1458. WEBB, M. R. and HERMAN, A. **Achieving behaviors in beginning nursing students.** *International Journal of Nursing Studies*, Oxford, 1978, vol. 15, no. 2, pp. 75-82.

The purpose of this study was to investigate and compare characteristics related to achievement of students entering baccalaureate and diploma nursing courses in the United States. It also investigated whether women entering nursing differed in these characteristics from other comparable groups of women. Ninety-five first year students were studied using four instruments which are described. Baccalaureate students scored higher than diploma students on two achievement scales used, but no other scores showed significant differences. All students scored higher than other women on fear of success and endurance, but lower on aggression and social recognition. Although baccalaureate students are more motivated to achieve, they do not differ much in other personality traits and, so, on entering their courses, the achievement potential of the two groups should be the same.

OTHER PROFESSIONAL AND TECHNICAL STAFF

1459. MEYER-HARTWIG, K. and BLEIFELD, W. **Education and professional training of biomedical engineers in West Germany.** *Journal of Medical Engineering and Technology*, London, 1978, March, vol. 2, no. 2, pp. 62-64.

The structure of the health services and the educational system in West Germany are outlined. Training routes in biomedical engineering are: (i) optional courses offered by research centres in universities; (ii) two-year post-graduate courses; (iii) specialized courses in technical high schools; and (iv) research doctorates. A field analysis carried out for the German Society for Biomedical Engineering involved questionnaires and interviews with staff in university and non-university hospitals, research institutes and industry. It is estimated that 1,500 biomedical engineers and 5,500 biomedical technicians are needed in West Germany; 60 per cent of the former and 90 per cent of the latter are required in hospitals. Numbers of existing staff are considerably lower

than the number needed. Two measures are required to correct the discrepancy: the economic benefits of biomedical engineering teams must be demonstrated; and training courses must be offered to hospital staff.

ORGANIZATION AND ADMINISTRATION

See also Abstract Nos. 1426, 1427, 1442, 1522, 1529

1460. DeVries, R. A. **Health care delivery: strength in numbers.** *Hospitals*, Chicago, 1978, March 16, vol. 52, no. 6, pp. 81-84.

The number and types of multi-institutional arrangements among health care facilities are increasing. It is suggested that the days of the completely autonomous, independent hospital are numbered. Although by themselves hospital systems are no panacea for dealing with the challenges which hospitals face today, many such arrangements offer more opportunities than problems in coping with the rapid changes currently facing health care. The advantages and disadvantages of seven multi-institutional arrangements are discussed in detail: formal affiliation; shared or co-operative services; consortia for planning or education; contract management; lease, corporate ownership but separate management; and complete ownership.

1461. McMillan, N. H. **Planning for survival: a handbook for hospital trustees.** Chicago, American Hospital Association, 1978, vii, 114pp. $12.50

This book is about strategic planning for hospitals and is intended for those trustees, administrators and doctors who have realised that many hospitals in the United States are in a state of crisis and need a new kind of planning effort. The book is in six sections: getting organized; getting the facts together; considering the future; putting the plan on paper; putting the plan to work; and the final result. The author suggests that the techniques of long-range planning he uses in business can and should be adopted by all hospitals; each chapter points out why and how things should be done, and what should not be done.

1462. Können, E. Beleidsalternatieven bij fusies van ziekenhuizen. **[Management alternatives following hospital mergers.]** *Ziekenhuis*, Utrecht, 1978, May 24, no. 10, pp. 266-269.

Part one analyses the problems encountered in 10 hospital mergers. These include: (i) problems of reorganization, which need decisions on how far a (smaller) hospital can keep its location, on concentration of resources, re-allocation of functions, and the minimum requirement during the interim period for one administration, board and management, one co-ordinated admission system and one medical staff. Every integration measure should be tested against expected resistance; (ii) problems of an enlarged scale: a more formalized organization with an increased hierarchy of administration reduces personal initiative and creates apathy. In order to maintain a good working climate the size of the departments, particularly the nursing units, is important. Decentralization where possible and re-training of staff are recommended; (iii) problems of a loss of position: promotion, lowering of status or dismissal, the latter particularly in key functions, are anxieties for staff. Decisions must be made on timing

of dismissals, natural wastage, division of functions, where to concentrate, and the position of specialists with private practice; (iv) problems of management: this area suffers from a high rate of dismissals coupled with re-appointments of directors with increased responsibilities. The formation of a new management as soon as the decision for a merger is taken is recommended; (v) problems of administration: too much or too little interference on either side can be damaging. Efficient decision making must be coupled with taking account of human relationships. The question arises whether hospital mergers have not been too frequent and too far-reaching.

1463. ANTHONY, M. F. **Early planning helps hospitals run efficiently during strike.** *Hospitals*, Chicago, 1978, March 16, vol. 52, no. 6, pp. 105, 108, 110-112.

The Henry Phipps Psychiatric Clinic at the Johns Hopkins Hospital, Baltimore, found that the use of a contingency plan during an actual strike made the transition to a modified operational role relatively smooth and enhanced communication. The essential features of the plan are discussed under the headings: strike planning committee; operations centre; manpower co-ordination; remuneration policies; volunteers; supplies; security; communications; and financial considerations.

1464. FARLEE, C. **The computer as a focus of organizational change in the hospital.** *Journal of Nursing Administration*, Wakefield, Mass., 1978, Feb., vol. 8, no. 2, pp. 20-26.

This paper is designed to help nursing administrators and others assess the potential impact of technological innovations. The organizational changes often accompanying the introduction of hospital (or medical) information systems are examined and discussed under the following headings: hospital information systems—functional characteristics; theories of organizational change relevant to technological change; hospital information systems and means of achieving organizational objectives; progress of change; acceptance of innovations—socialization models; relevance of socialization models for hospital information systems; and selecting hospital information systems.

GOVERNING BODIES, COMMITTEES

1465. KOVNER, A. R. **Improving community hospital board performance.** *Medical Care*, Philadelphia, 1978, Feb., vol. 16, no. 2, pp. 79-89.

There has been little attention paid to improving hospital governances as an approach to controlling costs and improving the quality of care in community hospitals. The author examines assumptions underlying such an approach, describes various proposals, and presents criteria to be used in evaluating them. The author recommends governing board involvement in goal setting and monitoring activities. This requires the development of standards on hospital performance and governing board performance, as well as a methodology for external monitoring and external impact on the boards.

ECONOMICS OF HOSPITAL MANAGEMENT

See also Abstract Nos. 1439, 1473, 1502

1466. FRYE, J. W. **The impact of energy conservation on hospital design.** *Hospitals*, Chicago, 1978, Feb. 16, vol. 52, no. 4, pp. 105-106, 108-110.

As a result of the energy crisis, it is essential that energy efficient criteria be considered in the design of new hospitals or in the remodelling of existing ones. Major design considerations for energy efficiency are orientation, building shape, and building exterior. Design of energy-efficient health facilities need not imply any compromise of the essential health care environment or functions, but success does depend on the various design professions working together.

RUNNING COSTS

See also Abstract No. 1554

1467. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. **Hospital costing and the clinician: papers given at or prepared after a Seminar held at the NHS Training and Studies Centre, Harrogate on May 12 and 13, 1977.** (Harrogate Seminar Reports 1) London, DHSS, 1978, [iii], 35pp.

This booklet contains the edited versions of papers given at the first of a small number of seminars organized by the Department of Health and Social Security, which are designed to study the use of health service resources by clinicians. The intention of these seminars is to generate interest in the important area of resource use amongst those who are the major users of resources in the National Health Service—doctors. The topics covered by the papers include: a review of costing; the standard accounting system and the clinician; specialty and unit costs; comparative disease costing in surgical patients; incentives, budgets and planning agreements for clinical teams; budgets and Cogwheel; the clinician's view; and a summary and postscript. A list of 30 references and a list of attendances is included.

BED OCCUPANCY, ECONOMIC USE OF BEDS

See also Abstract Nos. 1518, 1543, 1547, 1564

1468. O'CONNOR, T. J. and EFURD, N. **System predicts patient census, forecasts staffing needs, costs.** *Hospitals*, Chicago, 1978, March 16, vol. 52, no. 6, pp. 95, 97-98, 100-101.

In order to determine staffing requirements for the anticipated patient load, the 401-bed Donald M. Sharp Memorial Community Hospital, San Diego, has closely monitored admissions, length of stay, patient days, and census. The information has been used to develop a forecasting tool in the form of a graph depicting bed reservations vertically and ratios (reservations—admissions) horizontally. In 13 adjusted forecasts, the system proved reliable within a 2.9 per cent margin of error. Four graphs and three tables are included.

1469. ALAND, K. M. and WALTER, B. A. **Hospitals in Utah reduce costs, improve use of facilities.** *Hospitals*, Chicago, 1978, March 16, vol. 52, no. 6, pp. 85-87.

A serious problem in rural areas is low occupancy for acute care beds and a desperate need for additional long-stay care beds. In Utah the problem is being approached

through the Utah Cost Improvement Program (or "swing-bed" concept), a flexible bed use system that allows underused acute care beds to be used for long-stay patients. Twenty-five hospitals, ranging in size from 10 to 92 beds and having historic occupancy rates of under 60 per cent, are allowed to operate the system. As a result all beds are more fully used and long-stay patients can remain near relations and friends.

ELECTRONIC DATA PROCESSING

See Abstract Nos. 1464, 1527, 1528

MEDICAL RECORDS

See also Abstract No. 1561

1470. WEBSTER, C. editor. **The preservation of medical and public health records: Conference 25 May 1977,** London, King's Fund Centre, 1977, 24pp.

A one-day conference was held at the King's Fund Centre in view of the mounting concern about the level of preservation of medical records which provided an opportunity for the exchange of ideas between members of medical and non-medical organizations. Three papers presented on the major aspects of the problem of the preservation of medical records are reproduced in full, and consider: the statutory position and its limitations; medical administration and records; and the local authorities in relation to the health of local communities.

1471. ZIMMERMAN, J. **Physician utilization of medical records: preliminary determinations.** *Medical Informatics*, London, 1978, March, vol. 3, no. 1, pp. 27-35.

This is a report of the ways in which 26 doctors use medical records. It was found that the terms of greatest importance to the physicians, from the viewpoints of frequency of use and of occasional interruption of the physician—patient transaction by absences —were the results of laboratory tests, X-ray data, patient history, and previous treatments. The most common general problems cited with the medical records were incompleteness (named by 38 per cent of the doctors), illegibility (27 per cent) and poor organization of the records (19 per cent).

1472. JONES, R. V. H. and RICHARDS, S. J. **Confidentiality and medical records.** *Journal of the Royal College of General Practioners*, London, 1978, March, vol. 28, no. 188, pp. 137-140.

Protecting confidential information disclosed to doctors has been one of the most important ethical traditions of the medical profession. However, the patient's right to such confidentiality is threatened because it is legally unclear how far ownership by the Government of the paper on which NHS records are kept or of the computer system in which they are stored confers right of access. It is hoped that the medical profession will examine the problem and offer suggestions as to how patient's confidences can continue to be protected in the future.

LEGAL ASPECTS OF HOSPITAL ADMINISTRATION

See also Abstract Nos. 1435, 1472, 1565, 1566

FINANCE AND ACCOUNTING

1473. SCHWEISHEIMER, W. Finanzielle Bedrohung der Krankenhäuser. **[The financial threat to hospitals.]** *Österreichische Krankenhaus-Zeitung*, Wien, 1978, April, vol. 19, no. 4, pp. 229-230.

During the past five years a number of 'hospital chains' have been created in the United States: at present there are 31 with a total of 84,000 beds and most of them are in western or mid-western States. The largest is 'Intermountain Health Care Inc' (IHC) with 21 hospitals in Utah and Idaho. These chains have helped smaller hospitals to become, or remain, financially solvent by giving them access to expensive equipment and enabling them to obtain discounts on supplies. They also help individual hospitals on problems of management and training. Chains give the small rural hospital the potential of a large city hospital. Since 1974 the hospitals in IHC have increased their annual income from $77m to $130m: IHC provides 58 per cent of all hospital service in Utah and 28 per cent in Idaho. Patients pay 28 per cent less per admission under IHC. One of the most important savings arises from the avoidance of unnecessary duplication of expensive equipment.

FINANCE

See also Abstract Nos. 1465, 1480, 1495, 1563

1474. WAGNER, D. J. COZ en de normstelling in de gezondheidszorg. **[The Dutch Central Hospital Charges Organization (COZ) and the fixing of health service charges.]** *Ziekenhuis*, Utrecht, 1978, May 10, vol. 8, no. 9, pp. 231-237.

The COZ is a private corporation set up jointly by hospitals and health insurance companies in 1962. It is legally recognized and consequently subject to the Acts on prices and on hospital tariffs. This means, among other things, that institutions cannot raise their charges without agreement with the COZ and the Minister of Health. The COZ has on its board an equal number of members of both groups and four independent members, plus a daily administration responsible for management and guidelines. Wages and salaries account for some two thirds of the total intra-mural hospital costs and though the health service can always raise hospital charges, the COZ defends its present stringent attitude on staff numbers on grounds of governmental advice and general economic decline. Guidelines by the COZ are subject to ministerial approval and in practice the COZ has always sought agreement in advance. In 1977 a hospital tariffs' scheme with a pre- and post-calculation was worked out in accordance with the hospitals' collective labour agreement. Figures are given for different types of hospital and per hospital day. The COZ would welcome more legal definition of its powers, but if a new Act, now before Parliament, becomes law, the COZ will be replaced by a public corporation with only independent members.

SUPPLIES AND STORES

ECONOMIC USE OF SUPPLIES, DISPOSABLES

See Abstract No. 1503

CATERING, DIETETICS, KITCHENS

HOSPITAL CATERING

1475. GÜNTHER, H. Grossküche im Krankenhaus. **[Large-scale catering in hospitals.]** *Österreichische Krankenhaus-Zeitung*, Wien, 1978, April, vol. 19, no. 4, pp. 226-228.

The author, a representative of a German firm of kitchen equipment manufacturers, describes, with a sketch plan of the kitchens, the catering service planned for a modernized 660-bed hospital with a staff of about 500. In all 400 patients were to take meals in ward dining rooms (in groups of 30 to 40), while some 80 bedfast patients were served at the bedside. Individual portions were placed on trays in the kitchen and transported to wards where ward staff carried the trays to the dining tables or bedsides. Cafeteria meals for staff were transported in containers and portioned in the cafeteria. Only such items as glasses and cups were washed up by hand on the wards, all other crockery and cutlery were returned to the kitchens for cleaning.

1476. RIBA, L. Tapasztalatok a gyorsfagyasztási technológia kórház-élelmezési alkalmazásáról. **[Experiences with the quick-freeze system in hospital catering.]** *Egészségügyi Gazdasági Szemle*, Budapest, 1977, Dec., vol. 15, no. 4, pp. 467-473.

Following the experience of countries applying advanced catering technology, the Vác Hospital has adopted—for the first time in Hungary—quick-freeze large scale food preparation and the vacuum packaging system. The economic manager of the hospital discusses the advantages of the system: there are fewer labour shortage problems in the hospital kitchen; the productivity of the cook's work has increased; and the period of using seasonal raw materials has lengthened. Bacteriological problems have not occurred during the experimental stage of producing 40,000 meals in the Vác Hospital. The application of this system to other hospitals is expected.

DIETETICS IN THE HOSPITAL

1477. EVANS, E. **Quality of diet received by the patient.** *Proceedings of the Nutrition Society*, London, 1978, May, vol. 37, no. 1, pp. 71-77.

This paper first examines the hospital diet from the point of view of the quality of the diet as delivered to the ward, including losses of nutrients during cooking, and then looks in more detail at levels of food intake in patients. Examination of a number of studies demonstrates very clearly that the most important people involved in the feeding

of hospital patients are the ward staff who actually serve the food to the patient and to whom the patient turns with regard to his dietary problems. The onus of seeing that patients receive the right food increasingly falls on ward staff, as the trend is to incorporate special diets into the normal hospital menu and for them to be prepared in the main kitchen. Improvement can come only if the whole chain of people concerned, especially the ward staff, are made to understand the importance of diet in the treatment of some diseases and its value for the speedy recovery of all patients.

1478. COUBROUGH, H.A. **The role of dietitians in hospitals.** *Proceedings of the Nutrition Society*, London, 1978, May, vol. 37, no. 1, pp. 65-70.

The work of dietitians in hospitals can be divided into four main categories: advisory; educational; therapeutic; and research and investigation. In their advisory role dietitians must liaise closely with the catering officer in three areas: (i) planning of menus to ensure that nutritionally balanced meals are available to all patients; (ii) methods and timing of cooking to ensure retention of nutrients; and (iii) assessment of new foodstuffs. In their educational role, dietitians assist in the training of diet cooks and nurses, and sometimes medical students, and in the health education of patients. Therapeutic diets can be considered as essential, prophylactic or palliative. Research and investigation involve dietitians in work which requires a high degree of patience and attention to meticulous detail.

1479. SCHEEL, J. P. and MCCLUSKY, K. W. **Standards of performance developed for clinical dietitians.** *Hospitals*, Chicago, 1978, March 16, vol. 52, no. 6, pp. 157-158, 160, 162.

Although standards of performance are common in industry, they are relatively new to the health care professions. This paper describes the development of standards of performance for registered dietitians in a clinical capacity at Barnes Hospital, St. Louis., Miss. After one year the standards were reviewed. The changes made are listed. The benefits and costs of the programme also are explained. An extract from the standards is reproduced.

LAUNDRIES AND LINEN SERVICE

LAUNDRIES

1480. ELLIS, B. **Cost containment in laundry and linen service.** *Hospitals*, Chicago, 1978, March 16, vol. 52, no. 6, pp. 141-142, 144, 146.

One major problem stands out in determining whether a hospital has an in-house laundry and linen service, is part of a shared or central laundry, or uses a commercial service—the costly problem of controlling linen consumption and replacement. This paper provides a summary of a recent seminar held by the American Hospital Association which offered some insight into the problem and some possible solutions. These include serious reconsideration of linen practices, streamlining the linen mix, prevention of theft, greater responsibility for laundry managers, and the backing of top administration.

1481. National Staff Committee for Accommodation, Catering and other Support Services Staff. **A report on the recruitment and training of laundry managers.** London, D.H.S.S., 1977, 35pp.
Enclosure to HC(78)13

This report on the training and recruitment of laundry managers within the National Health Service is in four sections. Section one is an introduction to the background of the report; section two considers the management structure; section three considers recruitment and manning and the training implications; and section four considers the problems of training in laundry management. Various recommendations are presented including the need to recruit from the commercial sector, the need for a cohesive career structure, and the fact that employing authorities must be prepared to recruit and train potential laundry managers. Two appendices are included: a survey of Managers and Assistant Managers in post at 31 August 1976, and a general description of the standard training programme for laundry managers.

1482. Department of Health and Social Security, Welsh Office and Scottish Home and Health Department. **Laundry. Revised edition** (Health Equipment Note No. 25) London, Her Majesty's Stationery Office, 1977, 18pp. £1.50

This Equipment Note gives guidance on the equipment required for a laundry. It is not concerned with transporting laundry articles to and from the hospitals served. Aspects considered include: cost; basic accommodation-list of rooms and associated schedules of equipment; and supplementary accommodation. Two appendices are included on departmental cost summaries and the British Standards which may be relevant to certain items listed in the Equipment Note.

HOSPITAL DOMESTIC MANAGEMENT

1483. Department of Health and Social Security. Domestic Services Management Branch. **General guide to the management of domestic services in the National Health Service.** (Domestic Services Management Advice Notes No. 3) London, Domestic Services Management Branch, D.H.S.S., 1977, 20pp.

This guide to Domestic Services is intended primarily for those concerned with the management of domestic services, but it may also be useful to health authorities in considering how best to organise or develop their hotel services on a cost-effective basis. The scope covered by the guide includes: management and supervision; operational policy; organization; control of infection; staffing; budgetary and cost control; staff training; equipment; residences management; housekeeping and ward orderly services; service contracts; pest control; refuse control; linen and sewing room services; and patient's clothing service. Two appendices are included covering housekeeping services, and management of a personal clothing service for long-stay patients.

DOMESTIC WORK

1484. **Annual cleaning and hygiene feature.** *Hospital Equipment and Supplies*, London, 1978, April, vol. 24, no. 4, pp. 17-20.

This feature consists of four papers on various aspects of hospital cleaning. The first paper considers the liaison between cleaning and infection control, emphasizing: (i) the importance of clean equipment; and (ii) the correct use of disinfectants and environmental sampling. The second paper describes the unit established at University College Hospital, London, for disinfecting and servicing complex equipment used in patient care. The third paper discusses the advantages of using contract cleaning in hospitals. The final paper describes various systems for controlling odours, including the use of sprays, filtration, ionization and, most effective of all, air conditioning.

HYGIENE IN THE HOSPITAL

1485. ASSOCIATION FOR THE ADVANCEMENT OF MEDICAL INSTRUMENTATION. **Proceedings: hospital infection control, Philadelphia, May 5-6, 1976.** (Medical Instrumentation Series AAMI-102) Arlington, Va., Association for the Advancement of Medical Instrumentation, 1977, iv, 106pp.

These proceedings of the Workshop on Hospital Infection Control consider recent developments in the protection of patients and workers from infection from the surgical and nursing point of view. The 17 papers submitted cover such topics as: sterilization; contaminated surgery; aseptic barriers; surgical gloves; sterility testing; regulations and standards; methods of monitoring; the economics of infection; malpractice and infection.

HOSPITAL INFECTIONS

1486. NYSTROM. La fréquence des infections acquises à l'hôpital dans les hôpitaux suédois. **[Incidence of hospital infection in Swedish hospitals.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1978, March, no. 390, pp. 39-44.

The author reports the results of a survey of the incidence of hospital infection (HI) among 4,250 patients in five Swedish hospitals on November 4th, 1975. Approximately 11 per cent of the 3,650 patients receiving intensive care and 59 per cent of the 589 receiving long-term care suffered from HI. Infections of the urinary tract account for 50 per cent of all cases. The incidence of HI was highest among patients in neurosurgery, oncology, paediatric surgery, bacteriology, and neurology. A further survey in one hospital on a day in February and a day in November, 1975, showed that the overall incidence of HI was identical on both days—12 per cent. The annual number of cases of A and B hepatitis recorded in Sweden between 1966 and 1976 has fluctuated between 1,260 (1974), 1,463 (1966), and 2,787 (1976). The author believes that the cost of recording every case of HI as it occurs outweighs the benefits, and that a survey of the incidence of HI in a sample of patients in excess of 5,000 on one day at intervals of two years or more is sufficient. The data from the various surveys are summarised in a series of seven tables.

1487. NEJMI, S. and BOCQUET, J.-P. Les infections et surinfections en milieux hospitaliers marocains. **[Infection and cross infection in Moroccan hospitals.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1978, March, no. 390, pp. 117-123.

Hospitals in Morocco are neither better nor worse than those in Europe, in the author's opinion, but some features lead to a high incidence of hospital infection. These features include: the predominance of bacterial, parastic, and viral diseases; the low standards of literacy and hygiene among the population; the predominance of young people; the shortage of doctors and nurses; large wards; and poor facilities for sterilization and disinfection. At the Mohamed V Military Training Hospital, Rabat, the following measures are observed in an attempt to reduce the incidence of infection: doctors, nurses, and visitors wear sterile gloves and masks; disposables are used as much as possible; the staff are screened regularly to detect healthy carriers; there is chemoprophylaxis for viral hepatitis and systematic screening for Ag-HB's; and kitchen staff and foodstuffs are checked bacteriologically. The article includes 11 tables listing the pathogens identified, antibiotics used, and desirable prophylactic measures.

1488. CHELGREN, G. and LAFORCE, F. M. **Limited, periodic surveillance proves practical and effective.** *Hospitals*, Chicago, 1978, March 16, vol. 52, no. 6, pp. 151-152, 154.

Little data exist as to which type of surveillance (continuous or periodic) is more effective against hospital infection. Lacking the resources for continuous surveillance, Veterans Administration Hospital, Denver, developed a periodic surveillance technique whereby for one full month out of every three, traditional surveillance activities were performed. The interim two months were used for a limited form of surveillance, more thorough epidemiological investigation, and monitoring and co-ordinating corrective measures. Over a three-year period the system has proved to be a simple, practical and effective method of identifying and monitoring trends in hospital infection. More importantly, the system has provided the infection control nurse with more time to spend on corrective measures.

1489. GLASGOW, J. F. T. and others. **Nosocomial rotavirus gastroenteritis in a neonatal nursery.** *Ulster Medical Journal*, Belfast, 1978, vol. 47, no. 1, pp. 50-56.

An outbreak of gastro-enteritis in the neonatal unit of the Royal Maternity Hospital, Belfast, began on the 20th November 1974 and new cases occurred until the 10th December 1974. Of the 61 babies who passed through the unit in this period, 14 were infected. Clinical details of the outbreak are given, together with the results of laboratory studies. Six of the 14 infants with diarrhoea and eight of the 17 without symptoms had evidence of rotavirus infection. The infection was confined to one cubicle for 17 days, then spread rapidly into four others. The source of the infection and the mode of transmission between the cubicles are unknown. Suggestions are made for containing future outbreaks.

1490. HARGISS, C. and LARSON, E. **The epidemiology of *Staphylococcus aureus* in a newborn nursery from 1970 through 1976.** *Pediatrics*, Evanston, 1978, March, vol. 61, no. 3, pp. 348-353.

Results of seven years of epidemiologic surveillance for *Staphylococcus aureus* in a newborn nursery at the University of Washington Hospital, Seattle, Washington, are

presented. A rise in *Staphylococcus aureus* colonization rates among newborn children from 1973 to 1976 was related primarily to the discontinuance of hexachlorophene bathing. Other contributing factors were the addition in 1972 of the umbilical site for culturing as well as anterior nares, the use, beginning in 1972, of an HCP—inhibiting medium for staphylococcal culturing; and the presence in previous years of the Hawthorne effect. A recommended programme of control of staphylococcal disease in the newborn nursery includes: concentration on improving each member of staff's individual techniques; continuance epidemiologic surveillance; and routine umbilical care with triple dye or bacitracin. Bathing of infants with hexachlorophene should be considered as a temporary treatment to be terminated as soon as the acute disease is controlled.

PREVENTION AND CONTROL

See also Abstract Nos. 1488, 1489

1491. DUBAY, E. C. and GRUBB, R. D. **Infection: prevention and control.** 2nd edition. St. Louis, C. V. Mosby, 1978, xvi, 179pp. £6.00

This book is intended as a guide to provide an overview of various aspects of the subject of the prevention and control of infection. It is divided into 12 sections which consider: micro-organisms and infection; infection control structure and organization; staff health service schemes; methods for the prevention and control of infection; categories of isolation or precautions; education; reporting systems; meeting the emotional needs of the isolation patient; legal aspects of hospital-associated infections; interaction of health services and the hospital infection scheme; guidelines for nursing the patient in isolation; and resources, including a bibliography and lists of audiovisual and educational materials. A glossary is included.

1492. BOTZENHART, K. and others. Kriterien zur hygienischen Beurteilung von Intensivpflegestationen. **[Criteria for the hygienic appraisal of intensive care units.]** *Zentralblatt für Bakteriologie, Parasitenkunde, Infektionskrankheiten und Hygiene*, I. Abt., Orig., B, Stuttgart, 1978, vol. 166, nos. 4/5, pp. 314-321.

The medical records of 100 randomly selected patients from each of seven different intensive care units were analyzed. They showed notable differences with regard to diagnosis on admittance, age, and other factors related to the risk of infection. As a result the type and number of medical procedures, use of antibiotics, length of stay, and mortality differed widely. The paper sets out a number of priorities for lay-out, staffing, organization and treatment related to the risk of infection: the intensive care unit must be regarded as differentiated; the number and qualifications of the nursing staff must be adequate; disinfection of instruments and utensils must take place at frequent intervals; there should be continuous epidemiological control, e.g. by an infection control nurse; all antimicrobial measures of a therapeutic or preventive nature must be checked bacteriologically and clinically; and legislative provisions and guidelines issued by the relevant authorities must be observed.

1493. RÜDEN, H., FISCHER, P. and BOTZENHART, K. Hygienische Anforderungen an das baulich-funktionale Konzept von Intensivpflegestationen. **[Hygienic requirements for the architectural-functional design of intensive care units.]** *Zentralblatt für Bakteriologie, Parasitenkunde, Infektionskrankheiten und Hygiene*, I. Abt., Orig., B, Stuttgart, 1978, vol. 166, nos. 4/5, pp. 305-313.

Three types of intensive care units are described and illustrated by means of diagrams: (i) all patients in a single room with all facilities for the supply and removal of materials; (ii) separate (single) rooms for septic patients and a multi-bedded room for aseptic patients with a common functional area; and (iii) separate septic and aseptic zones with separation of some sanitary facilities. Hygienic and microbiological studies have shown that none of these arrangements meet requirements for the successful control of hospital infections, for which the four basic needs are: only one bed in each room; each room unit to be provided with a complete treatment unit; each room unit to have its own sanitary fitments; and no contamination of clean goods during transport. Two units designed to meet these needs are described and illustrated. The first has single-bed units with a decontamination sluice for each; the second has single-bed units, a common corridor for supply and removal of materials and a central decontamination area for materials.

STERILIZATION

1494. SILLS. **The sterile supply department and its relationship to the operating theatre.** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1978, March, no. 390, pp. 73-77.

After briefly reviewing the history of the central sterile supply department (CSSD) in English hospitals the author describes her experience in Nottingham General Hospital where she inaugurated a Theatre Sterile Supply Department (TSSD) which now serves 22 operating theatres in the area, providing a comprehensive sterile pre-set tray service (instruments, dressings, drapes, and hardware) for surgical operations, supplementary items, single instruments, pre-sterile anaesthetic sundries to anaesthetic areas, pre-sterile medical and surgical sundry disposables, and a decontamination service for patient ventilators, suction apparatus, etc. She and her staff of 21 are responsible for collecting soiled equipment, decontaminating and cleansing equipment for re-processing, and the assembly, sterilization, storage, and distribution of packs and trays. The average production is 500 trays per week. The department is also responsible for the purchase and distribution of all CSSD packs (from hospital or industrial sources) to all wards and other departments within the South Nottingham District.

1495. TRESCHER, M. Coût comparatif d'une centrale de stérilisation et d'une stérilisation séparée. **[Comparative costs of central and separate sterilization departments.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1978, March, no. 390, pp. 64-68.

It is difficult to compare the costs of the four different systems of sterilization: (a) separate sterilization; (b) central sterilization; (c) a central sterile supplies department; and (d) the supply of sterile requirements by industry. The author devised a method for calculating the investment costs of (a), (b), and (c), and the running costs of (a) and (c). These showed that the investment cost of a central sterile supplies department (CSSD) was higher than that of (a) or (b), but the running costs were

lower. He suggests a method for calculating the 'unit cost of using a sterile object'; this unit cost can then be used in the preparation of patients' accounts.

1496. UNITED STATES. BUREAU OF HEALTH PLANNING AND RESOURCES DEVELOPMENT. **A manual for hospital central services.** (DHEW Publication No. (HRA) 77-4013) Washington, U.S. Government Printing Office, 1977, xii, 106pp.

This publication updates A Manual for Hospital Central Medical and Surgical Supply Services, published in 1966. The role of the Central Medical and Surgical Supply Service (MSSS) is outlined. The features considered by this guide include: general considerations; the scope of services, supplies and equipment; collecting and receiving; cleaning and assembling; care of portable equipment; preparation of special supplies and equipment; sterile linen processing, chemical disinfection; sterilization; storage and inventory; and dispensing of supplies and equipment.

AIR HYGIENE

1497. REBER. Hygiène au laboratoire. **[Hygiene in the laboratory.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1978, March, no. 390, pp. 56-60.

The incidence of accidental infection in the hospital laboratory is unnecessarily high and the author offers a practical guide to prevention. Most infections are transmitted by way of blood samples and the recommendations relate in particular to how these samples should be taken, stored, and transported, and the best way to open the containers. There should be no blood on the request forms and only Pasteur pipettes should be used. Gammaglobulin should be given prophylactically if a member of the laboratory staff cuts himself, if he sucks up blood or plasma accidentally, or if he gets test material splashed in his eyes.

DISPOSAL OF WASTE

1498. LEEDS. CITY COUNCIL. DEPARTMENT OF ENVIRONMENTAL HEALTH and LEEDS AREA HEALTH AUTHORITY (TEACHING). **Code of practice for the safe disposal of hospital wastes.** Leeds, Leeds City Council, Department of Environmental Health and Leeds Area Health Authority (Teaching), 1977, 5pp.

This Code of Practice was written as a result of increasing concern regarding the unsatisfactory disposal of hospital and medical waste in the Leeds area. Aspects of waste disposal considered include: various categories of waste; hospital and other premises; general waste; food waste; radioactive waste; pharmaceutical waste; disposable syringes, needles and cartridges; human tissues; limbs, placentae etc., animal carcasses; pathology waste; other categories of infected waste; incontinent pads, colostomy bags, kidney machine waste etc; bags and containers for the disposal of hospital waste; collection of hospital waste, etc., and related services offered by the local authority; and publicity and information.

1499. VANINI. Le contrôle des effluents des hôpitaux: aspects analytiques. **[Control of hospital effluents: analytical features.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1978, March no. 390, pp. 111-113.

The author examines Italian legislation on the prevention of environmental pollution by effluents and the EEC harmonization proposals on the subject. He suggests that

multidisciplinary, multinational research be carried out to standardize methodology in the domain of the analytical monitoring of hospital effluents.

1500. MAISONNET, M. and ENSELLEM, B. Élimination des déchets hospitaliers: enquête française. 1. Méthodologie. **[Elimination of hospital waste. French survey. 1. Methodology.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1978, March, no. 390, pp. 94-102.

A survey on waste disposal was carried out in 60 French hospitals to establish an inventory of hospital refuse and to draw up a methodological guide for the use of hospital managements. Waste was classified as: (i) refuse specifically related to hospital activity; (ii) domestic-type refuse; and (iii) various, not regularly disposed of. It was found that the volume of refuse varied with the size of the hospital, its policy as regards the use of disposables, and also with the status of the hospital; refuse specific to hospital activity being 30-40 per cent of the total in a university hospital and only 10 per cent in a rural hospital. A series of eight tables is presented which summarize the categories and capacity of the hospitals in the sample, the bed occupancy rates, volume of specific refuse per bed, volume of laboratory refuse, other refuse, and total volume of refuse.

1501. MAISONNET, M. and ENSELLEM, B. II.—Les circuits des déchets à l'hôpital. **[Elimination of hospital waste. II. Waste disposal systems in the hospital.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1978, March, no. 390, pp. 103-110.

In the second part of their survey the authors describe the waste disposal systems employed by the 60 hospitals in their sample. They discuss separately: (i) waste from medical, surgical, and obstetric departments; (ii) laboratory waste; (iii) domestic-type refuse, food in particular; and (iv) occasional refuse; and report the methods used for disposal, storage of refuse before disposal, and frequency of collection. The systems employed in many of these hospitals, and in particular those for the storage of waste before incineration or removal by the municipal refuse services, leave much to be desired.

1502. ROHR, F. **Hospital waste converted into energy source.** *Hospitals*, Chicago, 1978, Feb. 16, vol. 52, no. 4, pp. 151-152, 154.

Every day, Ingalls Memorial Hospital, Harvey, Ill., produces nearly 6,000 pounds of waste resulting in a monthly bill for $2,000 to remove it. Following an analysis of waste production and disposal and energy requirements, a waste-heat recovery incinerator was installed with an automatic loading device and an automatic ash unloader. The system converts 850 pounds of waste into 3,500 pounds of steam per hour, thereby providing about 10 per cent of the hospital's needs. Because the incinerator is semi-automatic, it reduces labour costs; in addition it saves waste compaction and removal costs and reduces fuel bills. A diagram and photograph of the incinerator are included.

1503. DURAND. La destruction du matériel non réutilisable. **[The destruction of disposable material.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1978, March, no. 390, pp. 114-116.

A questionnaire was sent to 187 hospital pharmacists in order to discover how disposables were destroyed; 76 per cent responded. The replies showed that the problem

of destruction had been considered in 66 per cent of hospitals, but the pharmacist had been consulted in only 28 per cent. Disposables were mainly destroyed by incineration on the premises. Special receptacles were provided in 94 per cent of hospitals and the receptacles were kept in a specific place before destruction in 63 per cent. They were collected by special staff in 45 per cent and they were hermetically sealed in 18 per cent. No specific precautions were taken as regards needles, gloves, probes, syringes, or glass bottles in many hospitals. The questionnaire reveals a disquieting state of affairs and the author suggests various improvements.

SAFETY MEASURES

See also Abstract No. 1534

1504. KÜTTNER, J. Sicherheit von elektrischen Anlagen und Geräten im Krankenhaus. **[Safety of electrical installations and equipment in hospitals.]** *Österreichische Krankenhaus-Zeitung*, Wien, 1978, Jan., vol. 19, no. 1, pp. 13-16, 18-20, 23-24, 26-30, 33-36.

Official Austrian statistics on electrical accidents for the years 1974 to 1976 indicate that there were no fatal accidents under the headings 'Health and welfare' or 'Electromedical equipment' during that period. But it is assumed, on the basis of data from other countries, that such accidents do occur where several electro-medical appliances are attached to a patient at the same time. This paper stresses the importance of continuing observance of electrical safety measures in medical areas. The electrical resistance of the human body and the tests for determining the amount of current which can give rise to ventricular fibrillation are described. The paper also includes a brief survey of Austrian regulations on the safety of electromedical equipment. There are 50 references to the literature.

ACCIDENTS GENERALLY

See Abstract Nos. 1565, 1566

PLANNING FOR MASS EMERGENCIES

1505. WRUHS, O. Vorschläge zur Ausbildung von Medizinstudenten und Ärzten in Katastrophenmedizin. **[Proposals for training medical students and doctors in disaster emergency medicine.]** *Mitteilungen der Österreichischen Sanitätsverwaltung*, Wien, 1978, April 15, vol. 79, no. 4, p. 92.

Since the end of the second world war there has been no systematic training in disaster medicine for medical students or doctors at Austrian universities. But every doctor should possess basic knowledge in this field with particular reference to the following aspects: emergency treatment; the causes of disasters; disaster risks; secondary disasters; the organization of mass transport and mass treatment; and hospital disaster planning. Medical students should be given instruction in basic disaster medicine during the third stage of their training and doctors should undertake special training in this field. It is proposed that an Institute of Disaster Medicine should be set up with the following responsibilities: planning university courses in disaster medicine;

nominating medical experts and representatives from voluntary organizations in this field; producing documentation on disaster medicine; and advising the Federal Ministry of Health and Environment and health directorates on problems of disaster medicine.

1506. WRUHS, O. Empfehlungen für die Erstellung eines Planes zur Versorgung von Katastrophenopfern im Krankenhaus (Katastrophenplan). **[Recommendations for the preparation of a plan for providing/caring for disaster victims in the hospital (disaster emergency plan).]** *Mitteilungen der Österreichischen Sanitätsverwaltung*, Wien, 1978, April 15, vol. 79, no. 4, pp. 90-92.

The main requirements for drawing up an efficient hospital disaster plan are described under the following heads: triage (essential that patients are graded according to severity of injury); organization (allocation of responsibility); warning and communications system; regulation of traffic; documentation; staff preparation; adequate provision of drugs and dressings; and exercises. Exercises should be carried out in sections in order to disturb hospital routine as little as possible. Sectional exercises could cover such separate items as: calling out staff not actually on duty; manning a central point; triage, with models; connecting emergency power or water supplies; evacuation; and setting up temporary accommodation. These exercises could be carried out in collaboration with voluntary organizations. It is important to tell those who have taken part in exercises not only about deficiencies and mistakes but also about positive results.

RADIATION HAZARDS

See Abstract No. 1525

THE PATIENT

WELFARE OF THE PATIENT

See also Abstract Nos. 1452, 1509, 1513, 1519, 1558

1507. CASELLA, C. **Training exercises to improve inter-personal relations in health care organizations,** New York, Panel Publishers, 1977, x, 404pp. $14.95

This book is designed to be used by itself in training programmes, or in conjunction with other teaching techniques, and provides a series of training exercises and supporting written material aimed at improving the inter-personal relationships in health care organizations. The book is in 11 sections which consider: the individual in the group; the individual in organizations; inter-personal communications; organizational communication; the nature of the problems; the solutions leadership, control and evaluation; conflict management organizational climate; managing innovation and change; and career and personal goal-setting. A bibliography of 49 items is included.

1508. FAGIN, C. M. and NUSBAUM, J. G. **Parental visiting privileges in pediatric units: a survey.** *Journal of Nursing Administration*, Wakefield, Mass., 1978, March, vol. 8, no. 3, pp. 24-27.

Questionnaires were sent to 1,154 hospitals throughout the United States to identify the extent to which unlimited visiting by parents is allowed in children's units. Sixty-two

per cent of the sample indicated that parents were permitted 24-hour visiting. There were no differences between hospitals that did and those that did not permit such visiting in relation to unit size, census, age of children, diagnosis, or length of stay. There were, however, interesting regional variations in the percentage of hospitals allowing 24-hour visiting: the lowest percentage was found in the north-east region—a region which has the greatest percentage of highly educated physicians and nurses and the oldest traditions in both fields.

VOLUNTARY SERVICE, VOLUNTARY WORKERS

1509. CHRISTIE, D. and LAWRENCE, L. **Patients and hospitals: a study of the attitudes of stroke patients.** *Social Science and Medicine*, Oxford, 1978, Jan., vol. 12, no. 1A, pp. 49-51.

Sixty survivors of strokes were interviewed six months after their original admission to the Royal Melbourne Hospital. Their attitudes towards the hospital were not associated with social class, degree of final disability or length of stay, but were related to age and sex. Older men regarded the hospital and especially the doctors less favourably. In the case of women, this trend was reversed. The technical skills of the medical staff were highly regarded by most respondents, but their ability to communicate was often felt to be inadequate, and for 12 non-English speaking patients, the lack of communication was a significant cause of stress. Corrective action has now been initiated in Melbourne.

HOSPITAL SOCIAL WORK

See also Abstract Nos. 1538, 1552

1510. CAPUTI, M. A. **Social work in health care: past and future.** *Health and Social Work*, New York, 1978, Feb., vol. 3, no. 1, pp. 8-29.

Historically, social work in hospitals has been subordinate to the medical profession. Its development is traced through five phases from the turn of the century to the present day. The author suggests three ways in which hospital-based social work can effectively play a role in the area of policy-making as the equal of other professions in shaping health care decisions and practices: (i) it must be revitalized in the area of medical care; (ii) there must be re-evaluation of the standards used in granting accreditation to facilities; and (iii) incentives and sanctions for social work research in medical settings must be developed.

1511. AUSTIN, M. J. and KOSBERG, J. I. **Social work consultation to nursing homes: a study.** *Health and Social Work*, New York, 1978, Feb., vol. 3, no. 1, pp. 60-78.

A study is reported of 39 social work consultants to nursing homes in the south-east of the United States who continued their consultation activities after the federal requirement for such services to qualify for reimbursement was withdrawn. It examines their knowledge and attitudes about ageing and their consultative skills in relation to case, process and programme consultation and three types of group work (orientation, task and therapy groups). The study raises important questions for further research.

TRANSPORT OF PATIENTS

See Abstract Nos. 1542, 1544

HOSPITAL CARE

See also Abstract Nos. 1448, 1453, 1454, 1465, 1479, 1506, 1523, 1548, 1555, 1557, 1558

1512. SEEDOR, M. M. **Body mechanics and patient positioning: a programmed unit for nurses.** New York, Teachers College Press, 1977, x, 238pp.

This is a programmed learning textbook aimed at providing nursing students with an introduction to body mechanics. Suggestions are made for exercises and positioning. There are four lessons: (i) overview; (ii) maintaining balance; (iii) the body in action; and (iv) the positioning of body parts. After each lesson there is a summary, a self evaluation test and a list of answers. A list of seven references is included.

1513. FAGERHAUGH, S. Y. and STRAUSS, A. **Politics of pain management: staff-patient interaction.** Menlo Park, Calif. & London, Addison-Wesley, 1977, xii, 323pp. £7.20

This book is written primarily for all those who work with patients in pain. It is in eight parts with 19 chapters and the aspects considered include: politics, organizations, and pain; routine, non-problematic pain; complex surgery, chronic illness and pain; inflicted pain; necessary and unnecessary pain; assessment, legitimation and relief of pain, living with incurable pain; birth process and pain; balancing the options; and politics, patient care and ideology. An appendix outlines the methods used to carry out the research.

1514. VALENT, P. **Issues with dying patients.** *Medical Journal of Australia*, Glebe, 1978, April 22, vol. 1, no. 8, pp. 433, 435-437.

Doctors are apt to behave as if they are fighting death rather than disease and often fail to be open about death with their patients. Patients too set up various defences against admitting to the possibility of death, and fear of death increases with the advancement of physical and emotional helplessness. Anxiety generally develops into anger, followed by a period of detachment, and finally, acceptance. Certain practical steps may be taken to prepare both staff and patients for death; (i) group staff meetings to discuss the most suitable treatment for patients; (ii) helping the patient to understand his feelings; (iii) maintaining human dignity as far as possible, and (iv) helping the patient's family. Facing the reality of death can remove unnecessary suffering.

1515. STRAUSS, A. L. and GLASER, B. G. **Anguish: a case history of a dying trajectory.** London, Martin Robertson, 1977, viii, 193pp. £6.95

This is a case history of a woman who entered hospital suffering from cancer and died there some months later. The dying trajectory is followed day-by-day and takes in the reactions and behaviour of nursing staff, doctors, and the patient herself. Her death highlights the need to solve many of the social-psychological problems of the

dying. An interrelated set of general recommendations is offered as a first step towards the improvement of terminal care.

1516. GREGORY, M. J. **Health care delivery by means of Health Maintenance Organizations.** *Australian Hospital*, Prahran, 1978, June, no. 20, pp. 5-7, 9.

Health Maintenance Organizations in the United States provide comprehensive health care services by a system of fixed payments made by members in advance, rather than by the older for-service method. They aim to expand services, stem rising costs and move the emphasis of care from treatment to prevention. The scheme has been shown to have advantages both for doctors and patients. The setting up of HMOs on a regional basis has been discussed in Australia and the author recommends the establishment of a pilot scheme so that the application of HMOs to the Australian setting may be properly evaluated.

1517. HUNT, R. S. and REDMOND, J. M. **Basic assessment model proves effective, adaptable, economical.** *Hospitals*, Chicago, 1978, March 16, vol. 52, no. 6, pp. 165-166, 168, 170, 172.

A programme for assessing the quality of hospital emergency services has been developed and tested by the Hospital Association of Pennsylvania. The major steps in the model are: (i) selection of records; (ii) screening of selected records; (iii) professional evaluation; (iv) corrective action; and (v) feedback and re-assessment. Twenty hospitals of varying size and activity participated in a three-month pilot study, the results of which are presented in this paper. At the end of the period, 88 per cent of the hospitals indicated that the programme could assist in evaluating patient care. All planned to continue it. It took about 28 man-hours to conduct each audit; the estimated total cost for auditing 50 medical records each month was less that $200. The forms used in the programme are reproduced.

1518. KAHAN, R. and TOBIN, R. G. **Utilization review can be a tool for improvement.** *Hospitals*, Chicago, 1978, March 16, vol. 52, no. 6, pp. 89-90, 94.

The decision of Professional Standards Review Organizations (PSROs) to delegate review activity to hospitals has led to considerable controversy. Hospitals seeking delegation must realize that not only their performance will be judged, but also their relationship with the PSRO. The capacities which each one of the over 50 review systems must provide are listed. The key elements in monitoring are timeliness and consistency, whether in admission certification or continued stay review. Procedures for the reconsidering and appeal of review decisions and the availability of an effective discharge planning programme are analyzed.

DISCHARGE OF PATIENTS

See Abstract No. 1549

SPECIAL DEPARTMENTS

WARDS

See also Abstract No. 1429

1519. MacArthur, C. and Wakefield, J. **Patients' acceptance of mixed-sex wards.** *Health and Social Service Journal*, London, 1978, May 26, vol. 88, no. 4593, pp. A21-A24.

Patients discharged from six mixed-sex wards in a Manchester hospital were sent a short questionnaire concerning their attitudes to mixed wards. Only 11.3 per cent objected to being in such a ward and objections were not related to the type of partitions in the ward or to the patient's complaint, but to more general everyday issues. Various suggestions for improvement were made, many of which could equally have applied to a single-sex ward. When asked about choice of ward type on any subsequent stay in hospital, over half the respondents did not mind which type of ward they went into, and the majority of younger patients said they would prefer a mixed-sex ward. Contrary to widespread opinion, this survey did not provide any evidence that mixed-sex wards are unacceptable to many patients.

ANAESTHESIA

1520. Vessey, M. P. **Epidemiological studies of the occupational hazards of anaesthesia—a review.** *Anaesthesia*, London, 1978, May, vol. 33, no. 5, pp. 430-438.

This paper provides a brief critical review of 12 published epidemiological studies (all using some sort of control data) of the possible occupational hazards of anaesthesia reported over a period of 10 years from the United States, the United Kingdom and Scandinavia. The findings of the studies are summarized in six tables. The studies provide reasonably convincing evidence of a moderate increase in the risk of spontaneous abortion among exposed females, although it is possible that even this result is attributable to reporting bias. There is no convincing evidence of any other hazard.

PHARMACY

1521. Adachi, W., Turner, F. E. and Boehm, R. C. **A clinical approach to the education of pharmacy residents at a Veterans Administration hospital.** *Drug Intelligence & Clinical Pharmacy*, Washington, D.C., 1978, Feb., vol. 12, no. 2, pp. 100-107.

At the 800-bed San Diego Veterans Administration Hospital, the pattern of care reflects an increased emphasis on returning the veteran to an ambulatory care status. In this environment the pharmacy has departed from its traditionally accepted role of drug storage and distribution and provides: a total unit dose distribution system; a centralized intravenous additive service; a radiopharmaceutical service; and clinical pharmacy services. The hospital has four positions for clinical pharmacy residents. Their duties and experiences are many and varied, the residents rotating through several units and services. Emphasis is placed on the residents becoming proficient in writing accurate notes in charts. The work carried out by the residents in the extended care facility, out-patient clinics and mini-satellite pharmacies is described. In the last named, emphasis is on drug monitoring, drug distribution and clinical services.

1522. Rubin, H. and Kuczmarski, L. **A managerial approach to modernizing pharmaceutical services.** *Hospital Pharmacy*, Philadelphia, 1978, April, vol. 13, no. 4, pp. 210-213, 217.

A managerial approach to the re-organization of a pharmacy department is described, using the pharmacy of the Niagara Falls Memorial Medical Center, New York, as an example. The first step in the process of upgrading services is to assess the current practices of the institution concerned; these assessments can then be compared with published standards and statistics. Once the purpose of the pharmacy department has been defined, it can be achieved by the use of management by objectives, a system whereby results are measured against set objectives. To define practical objectives, resources must be analyzed and the support of relevant staff acquired. A system of priorities must also be established. Various controls which can be used to evaluate results are listed.

1523. LAMY, P. P. and RILEY, A. N. **Considerations for a paediatric pharmaceutical patient care service.** *Drug Intelligence & Clinical Pharmacy*, Washington, D.C., 1978, Feb., vol. 12, no. 2, pp. 88-93.

Pharmaceutical patient care services for the ambulant paediatric patient will only be effective if special considerations are given to the patients, peculiarities. Often patients cannot communicate effectively and their health frequently depends upon the health status of the mother. Adolescents, in particular, present many unique and social problems. Paediatric patients receive fewer prescriptions than adults but drugs are frequently administered in the clinic. Often non-prescription drugs are prescribed.

1524. ESHELMAN, F. N., FITZLOFF, J. and TROYER, W. G. **Compliance rates for drug regimens in medical clinic patients.** *Clinical Trials Journal*, Sutton, 1978, vol. 15, no. 1, pp. 3-14.

Compliance with drug prescriptions was studied in 445 out-patients of a metropolitan university hospital clinic. Patients were characteristically unemployed, black adults with less than high school education. They were not informed that their compliance was being monitored. The medications most frequently prescribed were antihypertensives and oral hypoglycaemics. Compliance scores, based on pill counts made in the patients' homes, indicated that only about one-quarter of the patients were taking between 80 and 109 per cent of the prescribed medication. Ten per cent or more of the patients receiving some of the drugs were taking considerably more than prescribed. Assay of urine samples, taken at the patient's next subsequent visit to the clinic, proved a sensitive but not specific measure of compliance based on actual pill count. It is concluded that urine assay is a poor predictor of compliance. Statistical analysis indicated that none of the sociodemographic or clinical 'interaction' factors measured, including whether the patient was treated by nurse practitioners or by physicians, proved to be significant in predicting compliance.

1525. HILL, P. N. M. **Establishing a radiopharmacy unit.** *Pharmaceutical Journal*, London, 1978, May 27, vol. 220, no. 5972, pp. 430-432.

The unit described at Bristol is designed to achieve the aseptic manufacture of radiopharmaceuticals and the radiological protection of the operator. To comply with fire regulations and allow the smooth passage of materials between the aseptic room and the dispatch area, the design is very simple, with special attention to finishes. The unit consists of one aseptic room, a clean room and a changing room for each. The air in the aseptic room and the clean room is changed over 20 times per hour. Equipment

and procedures which afford radiological protection are described. Ninety-five per cent of the daily workload is for technetium-99m labelled radiopharmaceuticals, the preparation of which, together with quality control tests, is described in detail. Monitoring of areas for radioactivity and careful keeping of records are also important parts of the unit's work.

LABORATORIES

See also Abstract No. 1497

1526. HOËT, M. Conception architecturale des laboratoires d'hôpitaux. **[Architectural design of hospital laboratories.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1978, March, no. 390, pp. 48-55.

The author discusses the design of hospital laboratories in terms of site, general organization, lighting, noise, ventilation, materials, internal arrangement, and bench grouping and design. He pays particular attention to the siting of pipes and cables which must be accessible and may, therefore, be installed under a false floor or above a false ceiling. He suggests that a PVC covering is most suitable for the laboratory walls because of ease of cleaning and hosing. Finally, he discusses the layout and structure of the laboratory benches and the type of material which can be used for their construction. There are nine figures.

1527. SIEMASZKO, F. **Computing in clinical laboratories.** London, Pitman Medical, 1978, 302pp. £10.00

These papers were presented at the Second International Conference on Computing in Clinical Laboratories, held in Birmingham, England. The papers are divided into seven sections and consider: system design and implementation; microprocessors; cost effectiveness; experience of input/output devices in laboratory systems; interfacing and remote processing; computer assisted choice and use of laboratory results; and recent advances in numeric techniques. References are included after each of the 34 papers.

1528. LIZANA, J. Chile, modelo de un pais en desarrollo para la automatizacion del laboratorio clinico. **[Chile, a model of a developing country for the automation of clinical laboratories.]** *Boletin de la Oficina Sanitaria Panamericana*, Washington, 1978, March, vol. 84, no. 3, pp. 247-254.

The objectives of automation in laboratories, the types of equipment available on the market and the considerations to be taken into account in selecting such equipment are discussed. Chile now has 15 automated units, the first of which was imported eight years ago. However, their impact has not been as substantial as might have been expected in a country in which examinations have traditionally been made with manual instruments. The future of automation should be examined in the light of the prevailing economic conditions. The author believes that greater efforts should be made to use labour-saving apparatus since the advantages include: low unit costs; resistance to the environment; ease of handling and repair; and capacity for manufacture partly or wholly by local industry.

1529. DYSON, R. **The management of pathology laboratories: report to the Association.** London, Association of Clinical Pathologists, 1977, 23pp.

This report describes the present state of laboratory management as a result of a series of completed returns to a questionnaire circulated in 1977. The questionnaire attempted to collect information under two headings: factual information about the structure and management of pathology laboratory services and working practices in relation to the delegation of managerial authority; and opinions about any difficulties that may have arisen in the day to day management of the laboratories. Recommendations made as a result of the questionnaire are presented. The need for improved national guidance coupled with the introduction of local guidance on management structure is discussed.

1530. WORLD HEALTH ORGANIZATION. REGIONAL OFFICE FOR EUROPE. **The organization and methodology of cytology laboratories: report on a working group. Moscow, 16-20 November 1976.** (ICP/LAB 004) Copenhagen, WHO Regional Office for Europe, 1978, iv, 13pp.

This report of the Working Group on the organization and methodology of cytology laboratories has as its aim the identification of the function of cytology laboratories in health care in general and in screening in particular; the training requirements of staff; and the use of data processing. Guidelines are indicated which individual countries can adapt to suit local requirements. The identification of various factors, geographical, genetic and iatrogenic, allows activities to be concentrated on the most common tumour locations and helps to make better use of available resources and to identify high-risk populations with all the attendant benefits for cancer control.

1531. Perspectives de la biologie médicale. **[Perspectives on bio-medicine.]** *Administration Hospitalière et Sociale*, Montreal, 1978, Jan./Feb., vol. 24, no. 1, whole issue pp. 4-72.

This is a series of 13 papers, 11 in French and two in English, on various aspects of bio-medicine in the hospital environment, generally within the context of Canadian experience. The topics include the roles of the medical technologist, the professional biochemist, and the medical biochemist; the biomedical laboratory, costs, structure, performance, and management control; the assessment of automatic analysers; the use of computers in the biomedical laboratory; and future trends in laboratory equipment.

BLOOD TRANSFUSION DEPARTMENT

1532. BONAMOUR, P. Réflexion sur l'organisation de la transfusion sanguine en France et sur quelques problèmes qu'elle pose. **[Reflections concerning the organization of blood transfusion in France and certain problems it poses.]** *Hôpital à Paris*, Paris, 1978, March/April, no. 44, pp. 115-120.

A brief history of the development of the blood transfusion services in France and of the various structural changes which have been introduced over the past 30 years is followed by an account of the current situation. Blood transfusion services can only be established by public bodies and must be non-profit-making. There is one transfusion

centre in each *département*, and there are 15 dessication centres and four fractionation centres in different parts of France. The National Centre is situated in Paris, where there are also six hospital centres and a centre for perinatal haemobiology. The National Centre is responsible for research, training, and refresher courses. The hospital centres are responsible for both collection and distribution of blood in the capital.

1533. REVIRON, J. Hémobiologie-transfusion parisienne et collecte sanguine: aspects actuels du don de sang. **[Laboratory aspects of blood transfusion and blood collection in Paris. Current aspects of blood donation.]** *Hôpital à Paris*, Paris, 1978, March/April, no. 44, pp. 123-129.

More than 500,000 flasks of blood are used each year in Paris, but only 300,000 are donated in the city itself, and the rest has to be brought in from other parts of the country. The author suggests that the time taken for blood to reach the recipient from the donor could be shortened, that plasma, which has a longer life than whole blood, could be used more often, and that techniques such as plasmapheresis and cytopheresis should be developed and extended. He examines the problem of how to persuade more people to become blood donors and describes the current sources of donation. The transfusion services visit offices and factories; passers-by give their blood in specially equipped vehicles, and people visit the transfusion centres themselves. He suggests that more donors could be attracted if the services were given more publicity through the use of information stands, public relations men, donors' associations, and the press, radio, and television.

1534. MANNONI, P. and GENETET, B. La sécurité transfusionnelle. **[Safety in blood transfusion.]** *Hôpital à Paris*, Paris, 1978, March/April, no. 44, pp. 145-149.

The author examines the problems of compatability of blood groups, emergency transfusions in the absence of blood of the same group, ABO, Rh, and blood product compatability, and transfusions for the newborn. He suggests simple checking procedures which should be followed at each stage of the transfusion process in order to avoid the occurrence of accidents due to antigen/antibody conflict. He recommends greater use of cross-matching in conjunction with or as a substitute for the method in current use in France, namely, identification of the patients' antibodies and prescription of blood which does not contain the corresponding antigens.

REHABILITATION

See also Abstract No. 1536

1535. Frambu Helsesenter. **[The Frambu Health Centre (for the treatment, training and rehabilitation of the disabled).]** *Norsk Sykehustidende*, Oslo, 1978, April, vol. 51, no. 4, pp. 91-92, 94-96, 98-100.

Frambu Health Centre, built in 1975, is in a sheltered wooded area 11 miles from the centre of Oslo. Access and internal communications have been adapted for wheelchairs, handicapped patients, etc. Furnishings, wall and floor-coverings, bedding, etc., have been purchased with the asthma and allergy patients in mind. The Centre comprises a large therapeutic department, with physiotherapy, heated swimming pool,

occupational therapy, experimental kitchen, a technical aids section, and a dental health unit. The other portion of the Centre comprises a two-storey in-patients' department with room for six family units and 12 double rooms (72 patients in all). There is a common activities hall, and flats for 14 staff. The categories utilizing the Centre comprise: (i) asthmatics and allergy patients; (ii) haemophiliacs; (iii) cerebral paresis and myelomeningocele patients; (iv) (hereditary) cystic fibrosis patients; (v) epileptics; (vi) the mentally retarded; and (vii) rheumatics. Patients are referred by almoners (Sosialkuratorer), and the Centre is used for training social workers and dentists. The article is illustrated by a sketch of the outside.

DEPARTMENTS FOR SPECIAL THERAPY

1536. KRYSPIN-EXNER, K. Therapie und Rehabilitation des Alkoholkranken. **[The treatment and rehabilitation of alcoholics.]** *Öffentliche Gesundheitswesen* Stuttgart, 1978, March, vol. 40, special issue no. 1, pp. 33-38.

The many different groups of alcoholics present varying clinical pictures and need different types of treatment. This paper outlines the basic principles of such treatment and rehabilitation as conceived by the director of an Austrian psychiatric hospital. The most important role is played by the specialist out-patient department which first makes a detailed diagnosis and decides whether in-patient treatment is necessary. There should be one such out-patient department for each 250,000 inhabitants and the staff should include psychiatrists, psychologists, social workers, and psychiatric. Acute cases should be treated where necessary in intensive care units (which exist in every psychiatric treatment centre in Austria). Patients are also treated according to need in addiction clinics (Suchtkliniken) which should have a maximum of 80 beds, special units in psychiatric hospitals, special long-stay wards, special addiction clinics (of which there are 31 in West Germany with a total of 3,000 beds), or day or night hospitals. After treatment patients can either go to half-way homes or nursing homes for care and rehabilitation. Discharged patients should again come under the care of the specialist out-patient department for after-care. The system outlined here is perhaps complicated and expensive, but it would not cost the community as much economically as the effects of alcoholism on industry and on the family.

1537. BLAKE, D. R. and MITCHELL, J. R. A. **Self-poisoning: management of patients in Nottingham, 1976.** *British Medical Journal*, London, 1978, April 22, vol. i, pp. 1032-1035.

Analysis of the management of a sample of patients with drug overdoses in Nottingham in 1976 showed that some 10 per cent of the patients who arrived in the casualty department after an overdose were neither admitted nor seen by a psychiatrist. Of the patients who were admitted to medical wards for psychiatric evaluation, 31 per cent were thought to need no further psychiatric action, while the default-rate in those who were referred to a psychiatric out-patient clinic was 43 per cent. Both these end points showed considerable variations among the 10 psychiatric teams, but out of every 100 psychiatric patients with drug overdose who arrived in the casualty department, 51 went home without continued psychiatric or social action having been taken.

1538. LERNER, D. **Consultation on alcoholism in a general hospital.** *Health and Social Work*, New York, 1978, Feb., vol. 3, no. 1, pp. 103-125.

The alcoholism service at St. Vincent's Hospital, New York is structured around four components: in-patient unit; out-patient clinic; outreach programme; and consultation service. The first three form part of the department of psychiatry, and the consultation service deals with the alcoholism problem throughout the hospital. The aim is to provide education and consulation to existing hospital staff and to help them to upgrade the quality of treatment delivered to alcoholic patients. The development of the service is described and its future role discussed.

INTENSIVE CARE UNITS

See also Abstract Nos. 1492, 1493

1539. WIEMERS, K. Grenzen der behandlungspflicht in der Intensivmedizin. **[Limits of the duty to provide treatment in intensive care.]** *Deutsche Krankenpflegezeitschrift*, Stuttgart, 1978, June, vol. 31, no. 6, pp. 270-273.

The author, a leading anaesthetist, bases his views on 25 years experience in intensive therapy. He rejects the idea that the main duty of the doctor is to lengthen life at whatever cost. It is his view that the doctor's task—when no cure is possible—is to alleviate suffering and for this purpose intensive medicine is in the same category as hypnosis or acupuncture. The value of intensive medicine is evident when it is a question of a patient hovering between life and death and who may yet recover. But where the patient has no chance of recovering consciousness, intensive care is neither sensible nor necessary since it cannot help. Delaying death is neither a legal requirement nor is it defensible from the economic viewpoint. It is contrary to medical practice and inhuman. Intensive therapy should not be brought into disrepute by using it uncritically: it must be reserved for patients who have a real chance of recovery.

1540. HILL, J. D., HAMPTON, J. R. and MITCHELL, J. R. A. **A randomized trial of home-versus-hospital management for patients with suspected myocardial infarction.** *Lancet*, London, 1978, April 22, vol. i, pp. 837-841.

Hospital and home management of patients with suspected myocardial infarction were compared in a randomized trial in which a hospital-based team from Nottingham General Hospital answered calls from general practitioners. Out of 500 calls received, 349 patients were suspected of having myocardial infarction. Of those, 24 per cent were excluded on medical and social grounds. For the remainder, 76 per cent, there was no significant difference in the six-week mortality between the home group (13 per cent) and the hospital group (11 per cent). The results indicate that hospital admission offers no clear advantage for the majority of patients with suspected myocardial infarction.

1541. TURNER, G. O. **The cardiovascular care unit: a guide for planning and operation.** New York & Chichester, Wiley Medical, 1978, xvi, 512pp. £14.25

This book deals with the development of units capable of providing optional care for patients with acute cardiovascular pulmonary crises based on the work carried out

in St. John's Hospital, Springfield, Missouri. The aim of the book is to indicate how hospitals can upgrade and reorganize their cardiac and pulmonary care facilities to maximize quality, speed and cost control. The book is in five sections: (i) the problem and the solution; (ii) the St. John's CVCU experience; (iii) planning your own CVCU; (iv) managing your own CVCU; and (v) spending entry into the system. An appendix considers the original St. John's cardiovascular care unit from 1960 to 1972.

1542. HAMPTON, J. R. and NICHOLAS, C. **Randomized trial of a mobile coronary care unit [MCCU] for emergency calls.** Nottingham, Nottingham General Hospital, Department of Medicine, 1978, [19]pp.

A randomized trial has been conducted to assess the value of sending a mobile coronary care unit (MCCU) to all emergency calls other than those for children or for patients involved in road traffic accidents or brawls. During a 15-month period 6,223 calls for emergency ambulances were considered for the study, but a routine ambulance had to be despatched on 2,583 occasions because the MCCU was not available. One thousand six hundred and sixty-four patients were randomly allocated for transport by the MCCU, and 1,676 patients for routine transport. In these groups the pre-hospital mortality was 45 per cent and 47 per cent, and no patient survived resuscitation attempts long anough to leave hospital. During the same period, 190 patients with heart attacks were sent to hospital by general practitioners in routine ambulances, and none of them died during the period between the call for the ambulance and arrival at hospital. The data indicates that MCCUs as at present envisaged will not significantly affect mortality from heart attacks.

SPECIAL HOSPITALS AND UNITS

OUT-PATIENT

See also Abstract No. 1559

1543. DAVIDSON, S. M. **Understanding the growth of emergency department utilization.** *Medical Care*, Philadelphia, 1978, Feb., vol. 16, no. 2, pp. 122-132.

Much research on the use of hospital emergency departments has been published over the past 10 to 15 years, but the result has been large quantities of data which, when compared, produce inconsistencies which cannot be resolved without additional data from different sources. The question of why people who require medical care choose emergency departments as the site of care can best be answered by paying greater attention to illness factors than to the predisposing demographic factors upon which much research is focused. A tentative explanation for the growth of emergency departments is offered. Support from the literature is presented and the remaining questions are identified for future research.

CASUALTY AND ACCIDENT

See also Abstract No. 1539

1544. MACKINTOSH, A. F. and others. **The Brighton resuscitation ambulances: review of 40 consecutive survivors of out-of-hospital cardiac arrest.** *British Medical Journal*, London, 1978, April 29, vol. i, pp. 1115.

In the Brighton health district, three ambulances are fitted with resuscitation equipment and manned by staff trained in its use. Between 1974 and 1976, 40 patients were resuscitated before reaching hospital and survived to be discharged. Twenty-six of these had had circulatory arrest before the ambulance arrived and a further three developed ventricular fibrillation before being moved. Coronary ambulances can be effective for patients with sudden cardiac arrest as well as for those with recent myocardial infarction. The long-term prognosis of patients who survive resuscitation outside hospital is generally favourable.

1545. MULLNER, R. and GOLDBERG, J. **An evaluation of the Illinois Trauma System.** *Medical Care*, Philadelphia, 1978, Feb., vol. 16, no. 2, pp. 140-151.

The impact of the Illinois Trauma System is assessed in the southernmost region of the state. A sample of vehicular injuries and deaths are compared for a four-year study period: two years before implementation of the system, 1970-1971, and two years after implementation, 1972-1973. Decreases in mortality rates were experienced at trauma hospitals in 1972-1973 while mortality rates at these hospitals which did not become trauma centres remained constant. Trauma hospitals also exhibit significant declines in mortality rates during weekends and for the age group 45 to 64. When examined on a state-wide basis the Illinois Trauma System appears to have little impact on urban mortality rates but a substantial effect upon rural mortality rates.

1546. LAROCHE, C. and CAQUET, R. Rôle d'un service d'accueil médical dans les hôpitaux généraux: à propos d'une statistique établie sur un an de fonctionnement du service d'urgence médical de l'hôpital Cochin. **[The role of the patient reception department in general hospitals. Statistical study of the functioning over a one-year period of the emergency unit of Cochin Hospital, Paris.]** *Bulletin de l'Académie Nationale de Médecine*, Paris, 1978, Jan., vol. 162, no. 1, pp. 56-61.

The authors have studied the emergency medical service of Cochin Hospital, Paris, and point out that although real emergencies are rare, they justify the presence of adequate material for intensive care. They have observed a high percentage of psychiatric patients in need of hospital care or simple psychiatric advice. The authors believe that emergency medical units are good places for teaching students and that they should be run by doctors who are competent and interested in all aspects of medicine.

1547. STEINMETZ, N. and HOEY, J. R. **Hospital emergency room utilization in Montreal before and after Medicare. The Quebec experience.** *Medical Care*, Philadelphia, 1978, Feb., vol. 16, no. 2, pp. 133-139.

The impact of the introduction of Medicare in Quebec on hospital emergency department services was examined in Metropolitan Montreal. After Medicare, the emergency room visit rate increased 14 per cent per year compared to seven per cent per year increase in the five years preceding Medicare. The out-patient clinic visit rate continued in an upward trend (four per cent per year). Findings from six detailed

studies of hospitals, together with the increased population density of physicians and increased annual number of physician visits per person, suggest that there has been a substantial rise in demand from the public for medical care of which one important early manifestation is an increased reliance on emergency departments.

1548. CSÉPÁNYI, A. and SÉBESTYÉN, M. A sürgösségi betegfelvételi és betegellátó osztály mint a progresszív betegallátás elsö szintje. **[Admission and care department for emergency patients—the first level of progressive patient care.]** *Egészészgügyi Gazdasági Szemle*, Budapest, 1977, Dec., vol. 15, no. 4, pp. 424-429.

The emergency department of the Szolnok County Hospital, Hungary, was opened in July 1976. The patient turnover in the first 11 months was 9,078; 38 per cent of patients were treated as out-patients, 30 per cent remained in the admissions department and 32 per cent were transferred immediately to clinical departments. The average length of stay was 1.6 days in the admissions department. This system can be considered as the first step of progressive patient care.

1549. GIBSON, G. and others. **Walk-out patients in the hospital emergency department.** *Journal of the American College of Emergency Physicians*, Lansing, 1978, Feb., vol. 7, no. 2, pp. 47-50.

Between April 1976 and March 1977, 426 patients left the Johns Hopkins Hospital Adult Emergency Department before being treated. Of these, 179 were matched with controls to identify the characteristics of 'walk-out' patients. Half of those who visited the emergency department soon after the onset of symptoms, reported a great deal of discomfort at the time of the visit, but waited a relatively short time before leaving. The health of these patients did not seem to suffer for lack of treatment. However, an explanation of the reasons for a long waiting time should be given and a follow-up procedure for 'walk-out' patients adopted in order to maintain quality of care.

1550. KASZUBA, A. L. and others. **Evaluation of the emergency department as a site for hypertension screening.** *Journal of the American College of Emergency Physicians*, Lansing, 1978, Feb., vol. 7, no. 2, pp. 51-55.

A study was conducted in the Adult Emergency Department of the Johns Hopkins Hospital to see if it provided an appropriate setting for hypertension screening. All patients visiting the department had their blood pressure read and a reading of 95 diastolic or greater was taken to represent hypertension. Data to judge the suitability of the population served and the adequacy of follow-up were collected in an audit of a sample of emergency department records. The overall prevalence rate of hypertension readings was 19.5 per cent, but only 10 per cent were referred for follow-up. The potential screening coverage ranged from 9.9 per cent to 38.6 per cent with an overall community coverage of 24.2 per cent. Thus, in some emergency departments hypertension screening may be feasible, but should be supported by an adequate system of referral for further treatment.

OCCUPATIONAL HEALTH

1551. PLANT, J. **Small firms look to hospitals for occupational health services.** *Hospitals*, Chicago, 1978, March 16, vol. 52, no. 6, pp. 135-137.

Some hospitals are now offering occupational health services to small companies that

cannot justify establishing their own units. Typical of such hospitals are the 379-bed Salem (Mass.) Hospital and the 364-bed Family Hospital and Nursing Home, Milwaukee. Among the services provided are pre-employment medical examinations, routine examinations, prompt work injury care, and physician and nurse consultations and visits; some are on a contract basis and others on a fee-for-service basis.

DAY HOSPITALS

See also Abstract Nos. 1564, 1567, 1577

1552. LONDON BOROUGHS' TRAINING COMMITTEE (SOCIAL SERVICES). **Training for staff working in day centres for adults in need of care on account of mental illness, mental handicap, physical handicap, the problems of ageing: discussion paper.** London, London Boroughs' Training Committee (Social Services), [1978], [1], 19pp. £0.55

This discussion paper attempts to identify some of the knowledge and skills training which could be provided either through short courses, and in-service study courses, or as part of the qualifying courses, such as the Certificate in Social Service and the Certificate of Qualification in Social Work, for staff working in day centres for adults suffering from mental illness and physical handicap. The aim of the paper is to stimulate thinking about the specific training needs of staff working in day centres for adults. A list of courses provided by the Training Committee is included.

1553. DALL, J. L. C. **The contribution of the day hospital.** *Royal Society of Health Journal*, London, 1978, Feb., vol. 98, no. 1, pp. 10-11.

There are now 227 day hospitals in geriatric units in the United Kingdom, providing medical and nursing assessment and various types of therapy. The clinician decides the frequency of visits, treatment, assessment and discharge. A day hospital with 40 places can cope with 10,000 attendances, and an 80 per cent usage is normal. To make the system viable, the cost of day care should not exceed the cost of in-patient care. The availability of suitable ambulance transport and adequate liaison with general practitioners and social workers are both essential to the success of a day hospital.

CHILDREN

See Abstract Nos. 1508, 1523, 1578

GERIATRICS AND LONG-STAY

See also Abstract Nos. 1469, 1511, 1535, 1553

1554. UNITED STATES CONGRESS. CONGRESSIONAL BUDGET OFFICE. **Long-term care: actuarial cost estimates.** Washington, U.S. Government Printing Office, 1977, xiii, 100pp.

This technical paper provides detailed information on the demand for long-term health and social services in the United States, the existing supply of these services and

the cost of selected options for increasing them. Aspects covered include: general background on estimating the cost of long-term care services; spending under the present law for long-term care services; costs of two selected options; and the need for long-term care services. Two appendices are included which consider policy assumptions about benefits in long-term care options, and estimates of need and spending for long-term care services.

1555. ISAACS, B. **Recent advances in geriatric medicine. No. 1.** Edinburgh & London, Churchill Livingstone, 1978, ix, 172pp. £9.50

The increasing volume of information on geriatric medicine is an indication of the growing professional interest in the subject. This book is in two sections and considers the clinical problems of geriatric medicine and the provision of care for the elderly in Great Britain. Papers have been submitted from full-time physicians in geriatric care, and many of the advances recorded have been their own work. Other contributors come from a variety of disciplines. Bibliographies are included after each paper.

1556. SYKES, P. **Residential care of the elderly mentally handicapped.** *Royal Society of Health Journal*, London, 1978, Feb., vol. 98, no. 1, pp. 30-31, 35.

The elderly mentally handicapped should be able to live in their own homes wherever possible, through the services of home helps, community psychiatric nurses, and an emergency medical service. Sheltered housing, providing a home-like atmosphere, may also be suitable, but selection and acceptance by residents of each other is very important. Patients should not be transferred from one type of accommodation to another merely because they have reached a certain age. Admission to hospital should only be necessary when: (i) a patient needs a short stay in an assessment unit; or (ii) he has reached an irreversible state, when nursing skill should be directed towards terminal care. In the author's own hospital for the mentally handicapped, Greaves Hall, Southport, there are only 26 patients over 65 out of a total of 550 beds.

CANCER

See also Abstract No. 1515

1557. BURKHALTER, P. K. and DONLEY, D. L. **Dynamics of oncology nursing.** New York & London, McGraw-Hill, 1978, vi, 490pp. £10.45

The aim of this book is to provide in depth information on the status of cancer as a major health problem, the treatment methods used to intervene when cancer strikes, and the ever-expanding role of the nurse in the care of oncology patients. The book is divided into five parts. Part one presents background information on the nature of cancer from the physiological and the socio-cultural viewpoint. Part two explores the role of the nurse in terms of present contexts of practice as well as evolving and extended role development. Part three considers supportive aspects of the nurses' role in a variety of settings, hospital and community. Major issues the nurse faces while caring for the cancer patient, e.g. counselling and care of the dying person, are discussed in the other parts.

1558. BALDONADO, A. A. and STAHL, D. A. **Cancer nursing: a holistic multidisciplinary approach.** London, Kimpton, 1978, 287pp. £6.00

This book presents a multidisciplinary approach to nursing cancer patients. It is divided into six sections and covers: introduction to cancer and its etiology; detection and diagnosis of neoplasm; treatment modalities and nursing care principles; psychosocial aspects of cancer nursing; common malignancies, diagnosis and management; and metostatic cancer and related management. References are provided after each chapter and an index is also included.

1559. PLANT, J. **Teaching hospital nurtures growth of community oncology clinics.** *Hospitals*, Chicago, 1978, March 16, vol. 52, no. 6, pp. 121-122, 126-127, 130.

Boston University Medical Center's Regional Oncology Program (ROP) is currently running clinics for cancer patients in five community hospitals. The clinics are staffed by ROP staff and local nurses trained in cancer care. For those hospitals wishing to establish a clinic, ROP offers a total package or step-by-step approach. The four basic stages of ROP activity are: (i) establishment of a co-operative working relationship with a hospital; (ii) the transfer of recent knowledge on cancer control through lectures and workshops; (iii) the input of more intensive education and consultative tumour boards, and (iv) the development of a community-based oncology clinic. The operations of a clinic are described and the experience of that at St. Anne's Hospital, Fall River, Mass., is discussed. Brief details are given of the finance and administration of the programme.

NEUROLOGY AND NEUROSURGERY

See Abstract No. 1509

CARDIOLOGY

See also Abstract Nos. 1539-1542, 1550, 1563

1560. BOURDILLON, P. J. and HILL, D. W. **Electrocardiographic services: in two National Health Service regions.** *Health Trends*, London, 1978, May, vol. 10, no. 2, pp. 29-32.

A questionnaire on the provision of electro-cardiographic (ECG) services was distributed to 41 district general hospitals in the Northern and South-Western regions in 1975: 38 responded and 23 were visited the following year. The total number of ECGs recorded in 30 of the hospitals was 162,000 for 1974. Recordings of the 12-lead ECG were performed in various parts of each hospital, the single channel rather than the three-channel machines being used more frequently. Mounting an ECG recorder on a three-channel machine saved about two minutes of the technician's time per ECG. A service was provided for general practitioners by 18 out of 35 hospitals and exercise ECGs were performed at 15 of the 23 hospitals visited. As a result of their study the authors recommend: (i) standardization of mounting forms and their separation from request forms; (ii) more organized training in ECG interpretation; (iii) availability of resuscitation equipment during exercise ECG's; and (iv) a recording department designed to permit maximum flow using one machine.

1561. PEDOE, H. T. **Uses of coronary heart attack registers.** *British Heart Journal*, London, 1978, May, vol. 40, no. 5, pp. 510-515.

By studying all coronary heart attacks presenting within defined communities it should be possible to avoid the distortions and omissions inherent in hospital-based case series. In practice the technique presents several problems. Measures of frequency and outcome are very sensitive to the diagnostic criteria used. Data of varying quality are mixed and specific attack rates can be calculated only for items for which the census provides a denominator. Patients presenting to different medical services have different outcomes, but probably less because of the treatment than because the severity of the attack which affects behaviour in it. Despite these problems, some such intelligence system is of value in any comprehensive strategy for coronary heart disease.

UROLOGY

1562. OFFICE OF HEALTH ECONOMICS. **Renal failure: a priority in health? by William Laing.** [Studies of Current Health Problems No. 62] London, Officer of Health Economics, 1978, 60pp. £0.35

The incidence of treatable chronic renal failure in Britain and other Western countries is very small—40 people per million total population per year. However the importance of renal failure, in itself and as an illustration of the problems the National Health Service may have to face in the future, lies in the existence of a life-saving but highly expensive treatment in the form of dialysis and/or transplantation. The present situation under the National Health Service is outlined and future prospects discussed.

SURGERY

See also Abstract No. 1424

1563. MONRO, J. L. and others. **The cost of cardiac surgery.** *British Medical Journal*, London, 1978, June 24, vol. i, pp. 1684-1685.

A study in Wessex has shown that at 1977 prices, and excluding the cost of equipment already installed in the Cardiac and Thoracic Centre of Southampton Western Hospital, the cost of replacing a man's aortic valve is about £1,800. Nevertheless, this seems a small price to pay for return to health and full working capacity, particularly since such patients no longer need to draw social security benefits and their tax contributions will return to normal, thus probably paying for the operation within two years.

1564. BOURKE, J. B. and FINLAY, S. E. **The use and value of a University Health Centre with attached beds in the management of general surgical patients.** *Health Trends*, London, 1978, May, vol. 10, no. 2, pp. 42-44.

From 1975 to 1977, liaison between the Nottingham University Health Service and the university department of surgery resulted in 95 patients who had undergone elective surgery receiving their post-operative care in the University's Cripps Health Centre. The patients, 12 staff and 83 students, spent an average of 4.46 days as in-patients and only two needed an out-patient appointment. Ten patients not operated on

spent 47 days at the Centre and a further seven surgical cases spent 64 days there. The cost of care was £12.46 per in-patient day. The scheme is advantageous for students and, in the two years under review, saved the hospital service in Nottingham a total of 535 bed days. Other university health services should consider forming similar links with the university department of surgery and general practitioner health centres might well add in-patient beds in conjunction with a community hospital.

1565. MEDICAL DEFENCE UNION and ROYAL COLLEGE OF NURSING. **Safeguards against wrong operations: joint memorandum.** 4th edition. London, Medical Defence Union and Royal College of Nursing, 1978, 7pp.

This Memorandum sets out recommendations based on consultations between the Medical Defence Union and the Royal College of Nursing, and suggests precautions to avoid the risk of an operation being performed on (i) the wrong patient; or (ii) the wrong side, limb or digit. It is stressed that standardization of routine procedures will minimize errors, particularly as medical and nursing staff move from one theatre or department to another.

1566. MEDICAL DEFENCE UNION and ROYAL COLLEGE OF NURSING. **Safeguards against failure to remove swabs and instruments from patients: joint memorandum.** 5th edition. London, Medical Defence Union and Royal College of Nursing, 1978, 7pp.

This Memorandum sets out recommendations after consultations between the Medical Defence Union and the Royal College of Nursing. It points out that unintentional failure to remove a swab or instrument from a patient's body is negligence on someone's part and provides grounds for an action against the surgeon, the health authority or both; if the patient suffers ill effects he will be entitled to damages. Recommendations on safeguards for swabs and packs, instruments, and staff training and instruction are presented.

1567. RUCKLEY, C. V. **Day care and short stay surgery for hernia.** *British Journal of Surgery*, Bristol, 1978, Jan., vol. 65, no. 1, pp. 1-4.

With the decreased length of the post-operative stay in recent years, the repair of inguinal hernia has been considered one operation suitable for short stay, or even day care. Day patients are best catered for in a special unit and sufficient out-patient facilities are important. Special attention must be paid to the choice of premedication anaesthetic and post-operative analgesia, so that the early transfer from hospital to home is as smooth as possible. The general practitioner and the district nurse are responsible for post-operative care, but may seek re-admission at any time. Trials have shown that early discharge does not result in greater risk of complications. To avoid undue pressure on staff, day care and short-stay beds must replace a number of traditional acute beds. In addition, short-stay surgery must be supported by a well-organized general practitioner and community nursing service.

MATERNITY

See also Abstract Nos. 1489, 1490

1568. OSORIO, A. and others. Hospitalizacion conjunta del hijo con su madre—programa de madre participante. **[Joint mother and child hospitalization.]** *Boletin de la Oficina Sanitaria Panamericana*, Washington, 1978, March, vol. 84, no. 3, pp. 240-246.

The programme of a nursing mother's unit in Uruguay is described which emphasizes the advantages of a mother's staying with her sick baby to avert emotional and psychological disturbances; allows more attentive care of the child; reduces the incidence of in-hospital cross infection; shortens the time of confinement; continues and promotes breast feeding; and instructs the mother in hygiene and elementary technical ideas. An account is given of a maternal education programme through individual instruction, group discussions and direct participation of the mother in the care of her child. This programme does not require any increase in existing material and human resources, but only a more rational distribution of them into a structured programme of care by levels, in which the mother increasingly participates as the condition of her child becomes less serious.

1569. GORDON, D. and others. **Suburbia: a small obstetric hospital in Brisbane.** *Medical Journal of Australia*, Glebe, 1978, Feb. 25, vol. 65, no. 4, pp. 215-220.

In a 24-bed suburban obstetric hospital in Brisbane, during the period from 1 July, 1963 to 31 December, 1970, 3,760 private and intermediate patients were delivered by suburban general practitioners. The number of perinatal deaths in the hospital were nine deaths per 1,000 births, both live and still. During the same period 4,873 private and intermediate patients were delivered by suburban general practitioners in the private/intermediate section of a large centrally sited obstetric teaching hospital. The number of perinatal deaths in hospital were 18.9 per 1,000 births, live and still. The reasons for, and the implications of, these results are discussed.

DERMATOLOGY

1570. Hudkliniken firar 30 år. **[The Karolinska Hospital dermatology clinic celebrates its thirtieth anniversary.]** *KS-nytt*, Stockholm, 1978, nos. 1/2, pp. 38-43.

The dermatology clinic at the Karolinska Hospital, Stockholm was opened in 1948 with 156 beds—the first in Sweden. It has since been extended by the construction of an allergy clinic. Penicillin drastically reduced the need for venereological beds, but the clinic initially served as the central skin treatment unit for the entire country. Since 1968 the space has been divided into an infection department with 26 ward beds, 18 allergy beds and six occupational dermatology beds; a 26-bed week-day ward for psoriasis patients; a day-care ward, and a 15-bed infants' ward. In 1975, child care went over to day-care for all cases except those requiring full-time admission. There is an ultra-violet light department for e.g. Inggram's treatment for psoriasis, though care was revolutionized in 1975 by the introduction of the PUVA (Psoralene long wave ultraviolet) treatment. The clinic is also responsible for departments in Enskede (120 to 150 patients a day) and Kungsholmen (80 to 90 a day). Finally, there is venereal (sexually transmitted) diseases clinic, whose main problem today is Chlamydia infection. The article is illustrated with three internal photographs.

PSYCHIATRY

See also Abstract Nos. 1422, 1453, 1455, 1456, 1536-1538, 1556

1571. MARRAM, G. D. **The group approach in nursing practice.** 2nd edition. St. Louis, C. V. Mosby, 1978, xiii, 247pp. £6.80

This book considers the scope and nature of group work in nursing and illustrates the use of theoretical frameworks in guiding the study and practice of group work. It is divided into four sections: the scope of group work; theoretical orientations behind the study and practice of group work; the practice of group work; and considerations for the advanced practitioner. Aspects considered include: group physiotherapy; self-help groups; growth and self-actualization groups; reference groups; leadership functions; group practice; co-leadership and co-therapy; and typing behaviour. References are included at the end of each chapter.

1572. SHARFSTEIN, S. S. and WOLFE, J. C. **The community mental health centres program: expectations and realities.** *Hospital and Community Psychiatry*, Washington, 1978, Jan., vol. 29, no. 1, pp. 46-49.

Before the review by Congress of the 1975 Community Mental Health Centers Amendments, the National Council of Community Mental Health Centres and the National Institute of Mental Health held a workshop on the mental health centre scheme and the impact of current law. Problems relating to service delivery, accountability, financing and administration were discussed. The 1975 law expanded the services to be provided and concern was expressed at the inadequacy of funds to operate them. Questions were raised concerning the lack of in-service training at community mental health centres and the most suitable way of accounting and evaluating services. Some re-organization of the federal system of giving grants is needed if the centres are to function satisfactorily.

1573. ROBBINS, E. and others. **Unwelcome patients: where can they find asylum?** *Hospital and Community Psychiatry*, Washington, 1978, Jan., vol. 29, no. 1, pp. 44-46.

The psychiatric staff at Bellevue Hospital, New York City, have a list of patients whom they refuse to re-admit owing to their disruptive behaviour and refusal to co-operate with treatment. A study of 23 of such patients revealed that they are young men with few skills who respond to stress with rage, often combined with alcoholism and drug abuse. The authors recommend the development of therapeutic research units with varying treatment schemes in which newly discharged patients could be helped to overcome their impulses and become self-sufficient. The authors also consider that hospitals should provide adequate discharge planning and effective post-hospital supervision.

1574. MCPHAIL, N. I. **Behavioural disturbances in a general hospital psychiatric unit.** *Health Bulletin*, Edinburgh, 1978, March, vol. 36, no. 2, pp. 79-88.

Incidents which disrupt the smooth running of general hospital psychiatric wards are examined; it appears they are significantly related to certain patient variables,

including age and diagnosis. Younger patients, those staying longer in hospital, and manic-depressive cases are significantly more likely to be involved in incidents. Most incidents occur within a short time of admission, staff control measures are seldom necessary, and patients rarely require transfer to other units. It is calculated that most episodes of difficult behaviour can be satisfactorily contained in a general hospital setting.

1575. Veldwijk sluit fase 1 van renovatieplan af. **[Completion of the first phase of Ermelo's Veldwijk psychiatric hospital reconstruction plan: opening of the new 'de Maat' medical centre.]** *Ziekenhuis*, Utrecht, 1978, May 24, no. 10, pp. 260-261.

The paper is a report on the opening of the Centre on 6 April 1978 with extracts from speeches by the General Director and the Deputy Medical Inspector of Psychiatric Public Health. The first phase had taken 10 years to complete and comprised renovation of all admission and discharge units, their therapy and examination rooms. Eleven new buildings were erected, five completely renovated and 12 buildings plus a number of residences demolished. The number of beds was reduced from 880 to 800; the number of admissions rose from 400 to 800; new therapies (particularly forms of psychotherapy) were developed; an extensive system of polyclinics and day-treatment was installed; new attendant training courses were introduced. The second phase will be for long-term patients and ambulatory care. Though aiming at a non-institutional and homely atmosphere, the medical aspect is stressed with modern treatment methods achieving the shortest possible stay for patients. More legislation is recommended to guarantee good psychiatric treatment in cases referred to by the courts. The paper includes two pictures.

1576. KNEPSER, D. J. **Psychiatric manpower for state mental hospitals.** *Archives of General Psychiatry*, Chicago, 1978, Jan., vol. 35, no. 1, pp. 19-24.

A shortage of psychiatrists continues to exist in State mental hospitals (SMHs) in the United States and Public Law 94-484 is likely to aggravate this problem. A telephone survey was carried out on 50 State departments of mental health to collect data about: (i) the number and kinds of SMHs in each State; (ii) the percentage of psychiatrists in SMHs who are foreign medical graduates; and (iii) strategies for attracting psychiatrists to SMHs. Those States with SMH residency training programmes employed significantly more psychiatrists and paid significantly lower salaries than did States without these schemes. Nine States employed more psychiatrists and had a smaller proportion of foreign medical graduates than the remaining 41; salaries were similar. Sets of strategies for obtaining psychiatrists were identified for all 50 States. The strategies of competitive salaries, university affiliation and incorporating the SMH into an interdependent network of quality mental health care delivery systems are examined in detail.

1577. STEPHENS, A. and NATTRESS, P. **A study of day centres.** London, MIND, 1978, [ii], 67pp. £1.50

This report is a description of the work of seven day centres in England and Wales. Each of the day centres includes among the people attending, some who are either mentally ill or mentally handicapped. Each centre also places some emphasis on retraining and resettling into work. Various recommendations are put forward and

summarized. An appendix lists work carried out by additional day centres and there is a short bibliography of 20 items.

1578. BARKER, P. and others. **Living and learning: a nurse administered token economy programme involving mentally handicapped schoolboys.** *International Journal of Nursing Studies*, Oxford, 1978, vol. 15, no. 2, pp. 91-102.

The most successful approach to training mentally handicapped children in basic daily skills has been the token economy system (TE), which uses tokens for reinforcing behaviour performance. These tokens can then be exchanged for a desired item or activity. Ten boys, aged between eight and 15, from a paediatric ward in a hospital for the mentally handicapped, were selected for a pilot project using TE emphasizing routine self-care skills. Each of nine stages of the scheme expected a higher degree of unaided activity and tokens were given for satisfactory performance in all but the final stage. All subjects reached a high level of performance at each stage before progressing to the next, when only a slight drop in performance took place. The scheme shows how social behaviour can be improved and maintained by the use of and subsequent withdrawal of reinforcement procedures.

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